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(Spring 1993 to Fall 1996)

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Managed Care in the Medicaid Mental Health System: Verdict Out, Concerns Abound

Susan Fendell
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MHMA's mission is to improve access and quality of mental health services for Medicaid recipients and to make those services cost-effective.

> Agreement between the Department of Public Welfare-Medicaid, Mental Health Management of America and the Department of Mental Health

A bottom line emphasis on corporate profitability as the central value underlying the private sector component of our health care reimbursement system undermines the efforts of practitioners to provide human welfare-centered health care services.

> - Joseph S. Bak, Ph.D. and Robert H. Weiner, Ph.D., Issues Affecting Psychologists as Health Care Service Providers in the National Health Insurance Debate

Last Spring, the Department of Public Welfare (DPW) began to implement managed care for Medicaid recipients. Its implementation in the mental health and substance abuse systems has raised numerous concerns, but to date, the dearth of solid statistics and the lack of consumer feedback do not permit a full investigation of whether these concerns are well-founded. However, the way in which the system is structured may preclude consumer awareness of how managed care has affected the provision of mental health services.

Mental Health Management of America (MHMA), a Tennessee-based company, the statewide contractor for managed care implementation, began screening requests for inpatient hospitalizations in April 1992. In July 1992, MHMA assumed the role of gatekeeper for outpatient mental health services. In October 1992, MHMA awarded contracts to inpatient providers, who, except in emergency situations, will be the only inpatient providers eligible for Medicaid reimbursement in Massachusetts.[1] In January of this year, MHMA awarded contracts to outpatient providers, who likewise will be the sole providers eligible for reimbursement.

MHMA Network
Inpatient Hospitals

For Adults:

Cooley Dickinson Hospital
Noble Hospital
Franklin Medical Center
Wing Memorial Hospital
Berkshire Medical Center
North Adams Regional
Holyoke Hospital

Henry Heywood Hospital
UMass Medical Center
Medical Center of Central Mass
(Worcester Memorial)
Harrington Memorial

The Arbour Hospital
Carney Hospital
New England Deaconess
New England Medical Center
Mass General Hospital

Winthrop Hospital
Anna Jaques Hospital
AtlantiCare Medical Center
Lowell General Hospital
Salem Hospital
Holy Family Hospital
Malden Hospital
Baldpate Hospital (MR/MI)

Choate (MI/SA)
Newton Wellesley Hospital
MetroWest Medical Center
Mount Auburn Hospital
Cambridge Hospital

Fuller Memorial Hospital
Pembroke Hospital
Cape Cod Hospital
St. Lukes Hospital of New Bedford

Child/Adolescent Psychiatric:

Charles River Hospital West (10 and over)
Baystate Medical Center (under 10)

Children's Hospital

Brookside Hospital
New England Memorial
Amesbury Hospital

Somerville Hospital*
McLean Hospital
Cambridge Hospital
MetroWest Medical Center◇

Pembroke Hospital
Westwood Lodge
Fuller Memorial*
Cape Cod Hospital*

*adolescent only
◇children only

Inpatient Detoxification:

Hillcrest Hospital
Providence Hospital

AdCare

Faulkner Hospital

New England Memorial
AtlantiCare Medical Center

MetroWest Medical Center

Southwood Community Hospital

The financial incentives for MHMA to lower Medicaid expenditures were triggered in July 1992, when the capitated reimbursement agreement between MHMA and DPW commenced,[2] although those incentives were intensified in January 1993.[3] In 1992, MHMA stood to lose or gain a maximum of $300,000 based upon its ability to reduce inpatient admissions by six percent. A retroactive rate adjustment is to occur in April 1993 so that DPW pays no more than MHMA expended on direct services.[4] Neither DPW nor MHMA has produced the data necessary to determine whether MHMA has earned the $300,000 based upon reduced inpatient admissions.

In 1993, the stakes increased to $2 million. MHMA can profit (or lose) this money, depending upon the savings it achieves in direct service payments.[5] In addition, the capitated rate for disabled persons dropped from $105.34 in 1992 to $92.80 in 1993 and for other recipients from $26.51 to $25.13. However, these rates are subject to adjustment based on actual claims experience. DPW's portion of the savings realized must be credited to future capitated payments during the life of the contract.

DPW paid MHMA $6.49 million to administer the program from July through December 1992.[6] DPW also paid MHMA $81.17 million for mental health and substance abuse services. During the same period, MHMA paid or authorized $76.25 million on mental health and substance abuse services. The difference between MHMA "expenditures" and the amount DPW paid MHMA is slightly over $4.9 million. These figures are based on claims paid for the months July through September, and claims authorized for the months October through December. Not all claims for the first three months have been submitted, and therefore, it is likely that MHMA's savings are overstated. However, if one looks at an early month, it is reasonable to assume that a majority of the claims have been submitted,[7] and the savings shown are faithful to actual experience. Furthermore, while expenditures may be understated for outpatient services that do not require preauthorization, expenditures may be overstated for inpatient services that are authorized but not actually used.[8]

Difference between DPW payments for service and MHMA expenditures

July	$ 1.60 million
August	1.82 million
September	(430,000)
October	3.07 million
November	(22,000)
December	(1.12 million)
January	4.06 million

Whether or not these savings for MHMA will translate into savings for taxpayers is yet to be known. For the Commonwealth to break even, savings accruing to DPW must equal the amount paid to MHMA for administration less the amount DPW formerly paid a private company to process Medicaid claims.[9] The emphasis on cost savings, however, clearly will affect recipients because it affects the providers of their care.

The financial incentives for mental health care providers to self-censor services were triggered when it became public knowledge that MHMA would determine which providers would be eligible for Medicaid reimbursement.[10] A Medicaid recipient is entitled to notice and appeal rights if MHMA rejects or significantly changes a treatment plan proposed by her provider. Given the providers' concern about obtaining and keeping MHMA contracts,[11] it is unclear whether recipients can discover if their treatment has been tailored to the perceived cost control impetus of managed care. No notice rights are triggered if the provider, rather than MHMA, proposes a diminished level of service.

In fact, there is a paucity of appeals to date. MHMA reported 528 denials or diversion from July 1 through December 31.[12] Since the inception of the program in April 1992, there have only been 18 appeals, all through MHMA.[13] No recipient requested a fair hearing before DPW. There are many possible explanations, some more likely than others. One is that recipients requesting mental health services may not have the emotional wherewithal to fight a faceless corporation and/or a government agency. Another is that recipients may be loath to expose their need for mental health services to more persons, aware that persons with mental illnesses often are stigmatized.[14] Recipients may not receive or understand the notice of their appeal rights. Providers may discourage recipients from biting the hand that feeds the providers or may simply be unavailable to provide the professional support recipients consider necessary to successfully appeal. Or, MHMA may be "on the money" in their denials and diversions, leaving both recipients and providers[15] richly satisfied with the service approved or lack of service. It is not known how many requests for inpatient admission are at the behest of one other than the recipient. To the extent the attempted admission is involuntary, it makes sense that the recipient would not appeal an MHMA denial.

One of the hopes for the managed care system was that it would eliminate unnecessary hospitalizations and excessive lengths of stay. The inpatient admissions that have clearly declined are not those for purely psychiatric treatment, but those for substance abuse. Inpatient hospitalizations for substance abuse dropped by about 80 percent between July 1992 and January 1993. Detoxification in Level III and acute residential facilities increased by about 179 percent over the same period. The chart (upper right) shows the latest available data on substance abuse treatment.

The available data on the number of inpatient admissions for psychiatric purposes is contradictory and untrustworthy. No clear trends can be observed from the available information. Between July and December 1992, adult inpatient admissions show a slight decline, but January 1993 registered a large jump in these admissions. The number of inpatient admissions of children and adolescents appear to remain fairly steady between July 1992 and January 1993.

Substance Abuse Admissions

	In	III	R
July	395	312	
Aug.	313	350	
Sept.	279	460	
Oct.	174	430	99
Nov.	120	509	135
Dec.	98	480	150
Jan.	79	664	205

In - Inpatient Hospital
III - Level III Detoxification
R - Acute Residential

Admission numbers are subject to change as claims are adjusted. Numbers for recent months may overstate admissions.

Trends are discernible in the data on average length of stay.

- October 1992[16] 10.18 days[17]
- November 1992 9.04 days
- December 1992 8.55 days

While consumer advocates applaud the elimination of excessive lengths of stay, there is concern that persons are

Data provided by MHMA shows that as of February 9, 1993, the following facilities have joined the MHMA network:

- 8 Acute Residential Facilities for Children/Adolescents
- 1 Acute Residential Facility for Children*
- 5 Acute Residential Facilities for Adolescents**
- 18 Acute Residential Facilities for Substance Abuse***
- 4 Level III Detoxification Facilities

*MHMA also has contracted with an acute proctor care provider for children up to 10 years of age.

**Of these facilities, one is reserved solely for males and one for females.

***Two of these facilities are for adolescents only and one is for children and adolescents.

being discharged to inappropriate settings, leading to numerous short-term hospitalizations.[18] Although MHMA can point to residential services that are new to the Medicaid network (see table below left), it is not clear that any new beds have been created with the implementation of managed care. It is also murky as to whether the services now affiliated with Medicaid are being sufficiently utilized.

Reports from the field indicate that children are being discharged earlier from hospitals than prior to the implementation of managed care. While this often is a positive step, advocates for children have received complaints from providers and parents that children are being discharged to inappropriate settings.[19] They further complain that the children, who are placed on medications during their hospitalizations, are discharged without adequate arrangements being made to monitor the effects of the drugs.

As previously noted, statistics to date are inconclusive. The long-term impact of managed care on quality of care, unnecessary hospitalizations, and mental health care costs remains to be seen. The DPW contract with MHMA set a target goal of a six percent reduction in inpatient admissions for the period of July through December of 1992 over the prior six months. MHMA can earn $50,000 for each percentage point reduction beyond the goal, up to a maximum of $300,000.[20] It appears that MHMA has earned the maximum bonus on the basis of dropping substance abuse admissions and has not faced the more difficult issue of finding less restrictive alternatives for persons with acute mental illness.

Outpatient Services

As reported above, beginning January 1993, outpatient providers must be affiliated with the MHMA network to be reimbursed for services.[21] The following chart shows how many applications for network affiliation MHMA distributed, the number of full (one year) contracts awarded, and the number of interim (three month) contracts awarded as of January 27, 1993.[22]

Applications	1 yr.	3 mth.
Physicians		
2,209	252	212
Psychologists		
1,177	356	83
Mental Health Clinics		
263	68	67
Hospital Outpatient Clinics		
239	42	15
Substance Abuse Clinics		
108	53	27

Interim, rather than full contracts, were awarded if MHMA required additional information from a provider or had other questions about a provider's services. According to Thomas Salmon, MHMA Director of External Affairs, MHMA will deny network affiliation to no more than five percent of the providers awarded interim contracts. MHMA indicated that it will "weed out" outpatient providers next year.

Of concern to some mental health professionals is the use of protocols to determine appropriate outpatient care. Managed care has a reputation for focusing on short-term therapy and reliance on medication for long-term problems. According to the chairwomen of the Coalition of Mental Health Professionals and Consumers,

> In psychotherapy, only "brief therapy" (2 to 12 sessions) is considered good therapy. The focus is on a quick fix of symptoms and getting the patient "functioning." Some patients are forced to take medication under threat of denial of reimbursement for psychotherapy. Medication is sometimes necessary, often helpful, but used inappropriately, it can mask real problems, leaving patients in endless cycles of crises.[23]

MHMA outlined protocols based on groupings of diagnoses in its October 1992 plan for procurement of outpatient services.[24] These protocols specified the expected length and "intensity" of service during active treatment, rehabilitation, and maintenance, if any. If rigidly applied, these standards preclude individualized determinations of medical necessity. While MHMA stated that it would avoid micro-management of most individual outpatient cases, it did say that its outpatient service standards, including numerical parameters of frequency and length of treatment tied to diagnosis and level of functions, would be used to shape practice patterns.[25]

Even if MHMA understands the need for and permits deviations from these protocols, providers may strictly apply these protocols in determining the treatment plans for which they will request preauthorization. This is particularly true since MHMA warned providers that it will put outlier cases under "close scrutiny,"[26] and that "persistent disregard on the part of outpatient service providers of requests to bring their patterns of care within acceptable limits will result in termination from the network."[27]

MHMA is currently revising its protocols with the input of providers. MHMA expects 90 percent of outpatient services to fall within these guidelines.[28] MHMA does not favor long-term individual therapy, but prefers to stress short-term focused intermittent psychotherapy, as well as group and family therapy and self-help and

support groups.[29] Peter Gumpert, Ph.D., a Boston-based clinical psychologist, commented that issue-focused treatment plans are often a "sham".

> [T]hey are based on the assumption that psychotherapy is a social technology rather than the complex, highly sensitive relational process it actually is. While a therapist can "induce" a patient to "focus" on an issue during one or several treatment hours, such focusing is often utterly meaningless and unproductive. Indeed, it is contra-indicated when the patient is unready to bear whatever conflicts and feelings might lie behind the problem at issue.

He pointed to the example of an obese person whose eating disorder is part of a defensive structure that protects her from the memory of abuse by a parent. "Patients have their own internal program for the order in which their stories can unfold and their emotions can be experienced," Gumpert stated, noting that an attempt to treat the obesity without addressing the underlying problem would be ineffective.

The draft protocols recognize three phases of care: acute, active and maintenance. Acute treatment is permitted for up to four weeks, active treatment for up to six months, and maintenance treatment for an indefinite amount of time. Diagnoses are divided between psychoses, affective disorders, adjustment disorders, anxiety disorders, personality disorders, substance abuse, behavioral disorders of children, eating disorders, and "other".

Gumpert commented that these broad categories mask vast differences among, for example, subgroups of personality disorders and anxiety disorders, some of which require much more extended treatment than others. Furthermore, a person may present with one disorder, such as a personality disorder, only to reveal another, such as post-traumatic stress disorder, well after a safe alliance with the therapist is created. Another therapist noted that persons rarely fit neatly into a single diagnosis. Rather, they often fit more than one diagnosis or even no diagnoses, even though they are in considerable personal and even behavioral distress. She also contended that failure to consider support systems was problematic, explaining that treatment planning for an environmentally-supported person and for a homeless person with the same diagnosis is "so different as to be unrelated."

The draft protocols state that a recipient's inadequate progress toward objectives and failure to comply with treatment plans are criteria for discharge from outpatient treatment. The October 1992 protocols also said that a recipient's failure to cooperate or show improvement was a factor in cutting off outpatient care. "Patients vary greatly in terms of their initial responsiveness to treatment, and typically have periods of resistance to treatment," Gumpert said. Hence, a recipient's mental illness actually could form a basis for denying that person mental health care.

Upon completion of the MHMA protocol drafting process, treatment plans that do not exceed the maximum number of hours designated for each stage of treatment for a particular diagnosis will not be subject to clinical review. Upon review, the intensity and length of services will depend on the individual's level of functioning.[30] Until the draft protocols are finalized, services will be authorized on the basis of medical necessity per current Medicaid regulations, according to Salmon.

Conclusion?

Until all the numbers are in and "protocols" finalized, conclusions are not easily drawn. Only one is clear:

* Inpatient detoxification is on the decrease and detoxification in free-standing and acute residential substance abuse facilities will take its place.

It appears that less money is being spent directly on mental health and substance abuse services for Medicaid recipients than allocated for that purpose. Final assessments as to whether the quality of mental health care for Medicaid recipients improves or declines, or even a determination as to whether the Commonwealth will break even, will have to wait.

Endnotes

1. If a patient presenting at a non-network facility does not meet the criteria of an emergency admission but is suitable for a hospital level of care, MHMA will search for an available network bed. If none is found within an hour, MHMA will authorize admission to the non-network facility.

MHMA also may authorize non-network services if a "clinically necessary" treatment skill or capacity is not reasonably accessible within the network.

2. Capitation is a payment method that establishes a fixed, predetermined price for each person covered for a specified range of services during a defined time period. The provider has an incentive to provide the least expensive services while still meeting program guidelines.

3. DPW Contract with MHMA terminating Dec. 31, 1993, § 4.

4. A final adjustment of 1992 direct service payments will occur in December 1993.

5. The calculation of the additional $2 million compensation is based on eight percent of the difference between actual direct service costs and the direct service component of DPW capitated payments. DPW Contract with MHMA, Section 4.2(B)(2).

6. The capitation rate is broken down into administrative and direct service components.

7. Medicaid regulations require submission of claims within 60 or 90 days, depending upon the circumstance. MHMA did not hold providers to this requirement due to the early flaws in claims processing.

8. An emergency screening team may receive authorization for admission to a hospital only to later determine that the hospital in question does not have the capacity to admit the recipient. The team then seeks and receives another authorization to a different hospital. This happens frequently enough to cause a large difference between authorizations and actual claims experience. Furthermore, as of October, authorizations may be for longer stays than actually used and billed.

9. DPW paid about $700,000 for processing these claims in 1991.

10. Under the DPW contract with MHMA, MHMA can include subcontracted providers in the risk/savings arrangement. The maximum additional compensation to providers permitted is $3 million. According to James Michel, Director of DPW Mental Health/Substance Abuse Program, as of now, it is unlikely that any such arrangements will be made in 1993.

11. "Therapists may be forced to choose between compromising treatment or their ability to earn an income, as therapists are ejected from some networks if they average more than 6 to 12 sessions a patient or if they are too strongly advocates for patients." "The Trauma of Managed Mental Health Care," Joyce Edward and Karen Shaw, Chairwomen of Coalition of Mental Health Professionals and Consumers, *The New York Times*, p. A14 (Feb. 15, 1993).

Whether or not this particular scenario will become a reality in the Massachusetts mental health managed care system is yet to be seen. MHMA states in its literature that it expects the use of outpatient services to grow. It is unclear whether this means that the number of persons exposed to short-term therapy will increase as inpatient admissions are curtailed, and not that longer term therapy will also be available to recipients.

12. The number of denials and diversions reported by MHMA is low compared to the number of claims denied in its claims processing reports. In the processing reports, an average of 27 percent of claims are denied monthly. However, claims may be denied for numerous reasons, including the client was not eligible for Medicaid, a prior authorization was not on file, the claim itself was filled out incorrectly, or MHMA did not approve of the amount of service or the service itself. According to Michel, many of these claims are resubmitted and subsequently approved.

13. The initial MHMA decision was upheld in seven cases and overturned in 10 cases, and one case resulted in a negotiated settlement.

14. "Because of depression, anxiety, humiliation and the stigma of being in mental health treatment, most patients will not be their own advocates on this subject, publicly or privately." "The Trauma of Managed Mental Health Care," Joyce Edward and Karen Shaw, Chairwomen of Coalition of Mental Health Professionals and Consumers, *The New York Times*, p. A14 (Feb. 15, 1993).

15. Providers also have the right to appeal denials.

16. The available figures for July through September of 1992 do not represent actual lengths of stay, but rather an average of the theoretical length of stay used by each hospital in its Medicaid-negotiated RFA payment rate.

17. These numbers represent authorized lengths of stay for mental health treatment, adjusted for actual claims amounts as of February 10, 1993. The same trend is observable in substance abuse treatment:

- October 1992 9.38 days
- November 1992 8.43 days
- December 1992 7.94 days

18. According to Michel, MHMA will begin to produce monthly reports on recidivism in March.

19. The Massachusetts Alliance for the Mentally Ill expressed concern at a January meeting with MHMA, DPW, advocates and providers that adults are being discharged to homeless shelters and that recidivism has increased. This concern was echoed by a representative of the Massachusetts Psychiatric Association, who stated that she took no issue with the timing of discharges, only to where persons are discharged.

20. MHMA was also at risk at the same rate and with the same maximum for the failure to achieve the six percent reduction goal.

21. Recipients can call MHMA at 1-800-998-6462 and will be connected with a treatment service specialist who will provide referrals for mental health services.

22. In general, the outpatient procurement process was not a competitive one. Rather, all outpatient providers were offered a standardized contract. MHMA, A Plan for the Procurement of Outpatient Services for the Medicaid Mental Health and Substance Abuse Managed Care Program, p. 2 (October 1, 1992). MHMA did plan to conduct competitive procurement of psychological testing services (which it believes are over-used), methadone treatment, and mobile crisis intervention. *Id.* at p. 14.

23. "The Trauma of Managed Mental Health Care," Joyce Edward and Karen Shore, *The New York Times*, p. A14 (Feb. 15, 1993).

24. MHMA, A Plan for the Procurement of Outpatient Services for the Medicaid Mental Health and Substance Abuse Managed Care Program, Appendix A (October 1, 1992).

25. *Id.* at 2.

26. *Id.* at 5.

27. *Id.* at 7.

28. MHMA, Outpatient Protocols (Jan. 26, 1993)(draft), p. 1.

29. *Id.* at 2. Some consumer advocates are troubled that MHMA may encourage reliance on drugs, rather than on therapy, in an effort to control costs.

30. "Currently, MHMA is relying on the DSM III-R diagnostic assessment with an emphasis on Axes IV and V to allow for the focus on level of functioning." MHMA, Outpatient Protocols (Jan. 26, 1993)(draft), p. 2.

♦ ♦ ♦

Mental Health Managed Care: Service Expenditures Down MHMA Profits Up

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Managed care spurs diverse reactions from the various parties involved in our health care system. The party paying for the health insurance likes the lower costs it incurs. The provider resents the "micro-management" of health care decisions. The consumer is caught in the middle, often without any voice in her own health care.

Managed care has particular implications for low-income persons, who traditionally have little power over major decisions in their lives. This article examines the issues developing around Massachusetts' decision to use a private company, Mental Health Management of America (MHMA), to manage the mental health care of the majority of Medicaid recipients.[1]

Cutting the consumer out of care decisions

Under the current managed care system, consumers are, to a large extent, excluded from the process of making treatment decisions. Witness the following scenario: Dr. Day calls MHMA requesting prior authorization for admission of Consumer Pim to a day treatment program. MHMA refuses to grant prior authorization for the day program, but agrees to authorize six hours of outpatient treatment. Dr. Day consents. Does Consumer Pim get notice of this denial of her doctor's original request? No.

If a provider agrees to a diversion[2] or modification in treatment plan, the consumer does not get notice.[3] This policy is troubling given the financial interest of the mental health practitioner in pleasing MHMA for the purpose of remaining in its provider network. Granted, if a decision were clearly wrong, a mental health practitioner would likely object to it. However, much in mental health care is a judgment call and a practitioner is unlikely to jeopardize a significant source of income over a matter of discretion. According to one Department of Public Welfare (DPW) survey, two-thirds of providers express concern over appealing MHMA decisions due to contract concerns.[4]

The fact that a consumer does not get notice in the aforementioned scenario also appears to violate DPW regulations, which provide for notice to recipients in case of denial. The regulations define denial as "[m]odifications of treatment plans that result in a change in the type of service provided or in a reduction of services."[5]

The only financially disinterested person is the consumer who receives no notice of the process or her right to appeal the ultimate decision. Even in those rare cases in which MHMA acknowledges prior authorization was denied (an average of 5% of requests for inpatient care[6]), the notice given to consumers is deficient.

The standard denial notice and the standard diversion notice simply are not informative. The standard denial notice merely says:

> We have reviewed your request for hospital admission on behalf of the Massachusetts Department of Public Welfare's Medicaid Division. Based on the clinical information provided to us, we have determined that hospital care is not medically necessary at this time.

The notice then gives the telephone number of MHMA's benefit management agent to call to request a reconsideration, and also states that the consumer can mail in a form to request a formal hearing before the DPW.

The notice to the provider is not much better:

> After careful review of the clinical information provided to MHMA regarding the above named recipient, it has been determined that current symptoms do not support the need for hospital level of care....
>
> If you disagree with this decision, you may contact MHMA at 1-800-998-6462 to request reconsideration of this decision.

The standard diversion notice provides the same limited statement concerning the denial, adding a brief description of the services to which MHMA has agreed.

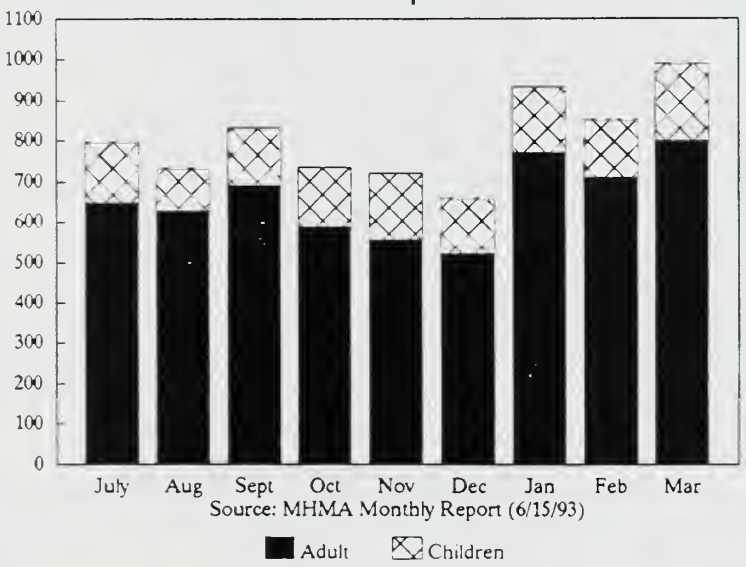
The number of appeals to MHMA[7] is extremely small, no formal appeals have been filed, and no fair hearings have been held before DPW, which oversees Medicaid. From January through June of this year, 80 requests for informal reconsideration and 12 informal appeals were filed.[8] People who asked for informal reconsideration had about a 50/50 chance of success. People who filed informal appeals had only slightly worse fortune.

DPW claims that the reason for the low number of appeals is provider satisfaction with MHMA clinical oversight. It also states that MHMA reports no denials of outpatient service.[9] DPW attributes this to self-censorship on the part of practitioners and to the program's "generous (8 session) initial encounter policy." Prior authorization is not required for a recipient's first eight sessions.

Trends in length of stay and admissions

The number of admissions to mental health hospitals has remained relatively stable between July 1992 and May 1993 (798 to 820), with the increase being primarily attributable to the hospitalization of adults. During the same period, the number of adult recipients hospitalized remained relatively stable, giving credence to fears about increased recidivism.[10] (See below.) Average length of stay decreased by about 13% between October 1992 and March 1993, from 12.67 days to 11.06 days. Preliminary data shows a trend toward even shorter lengths of stay: the average length of stay in April was 9.77 days.[11]

Adult and Children Inpatient Admissions



A significant drop in inpatient detoxification (Level IV)[12] admissions occurred between July 1992 and May 1993 (359 to 58). However, the use of less costly Level III and acute residential substance abuse services has substantially increased.[13] The average length of stay in Level IV substance abuse facilities dropped by 4% between October 1992 and March 1993, from 11.12 to 10.66 days. Again, preliminary data shows a trend toward even shorter lengths of stay. For example, the average length of stay in April was 9.46 days.

To deal with the problem of premature discharge, MHMA will pay a hospital for days when the recipient no longer needs hospital level care. The hospital must demonstrate "aggressive" discharge planning that provides for appropriate aftercare placement, and that the identified placement can not immediately accept the recipient for reasons beyond the hospital's control. Providers understand that MHMA does not relish the use of administratively necessary days. Indeed, a survey of 19 MHMA network hospitals found that most perceived themselves as having to discharge MHMA patients in the same or a shorter period of time, although they seem to be accepting more severely ill patients.[14]

Trends in Expenditures

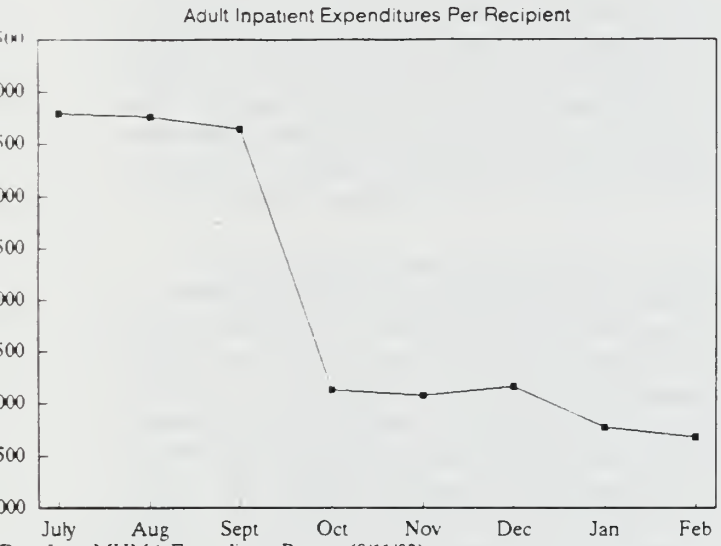
Although more recipients are being served, the overall expenditures for mental health services are

Change in MHMA Expenditures Per Recipient July 1992 through February 1993[15]	
Inpatient under 21	(63%)
Outpatient	(57%)
Psychiatric	(37%)
Inpatient adult	(35%)
Community health center	(32%)
Psychological	(11%)
Clinic consultation	(9%)
Clinic treatment	(8%)
Clinic medication	(8%)
Psych. day programs	(7%)
Clinic evaluation	(5%)
Crisis intervention	0%
Acute residential - child (Oct. to Feb.)	53%

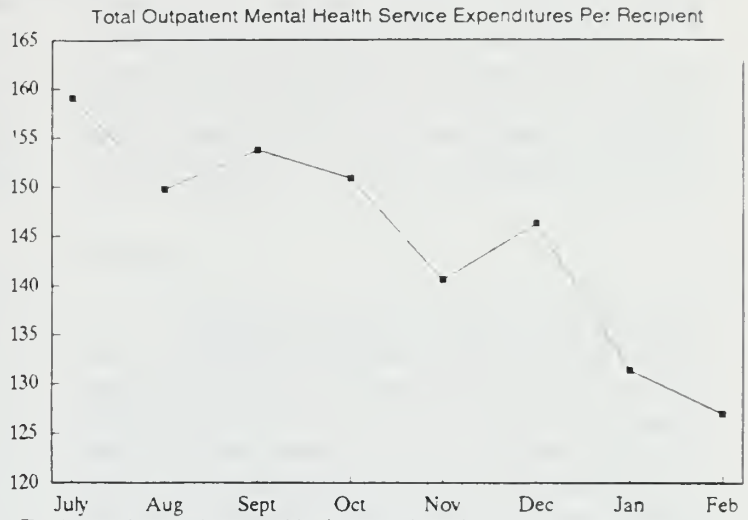
Change in MHMA Expenditures July 1992 through February 1993	
Psychiatric	(39%)
Inpatient	(38%)
Inpatient under 21	(30%)
Outpatient	(15%)
Psych. day programs	(14%)
Community Health Center	(11%)
Clinic medication	(6%)
Clinic consultation	(5%)
Clinic treatment	2%
Clinic evaluation	9%
Crisis intervention	39%
Psychological	86%
Acute residential - child (Oct. to Feb.)	396%

decreasing steadily. Between July 1992 and February 1993,[16] expenditures decreased 26% while the number of recipients served increased by 9%.[17] Most services experienced a drop in expenditures per recipient.

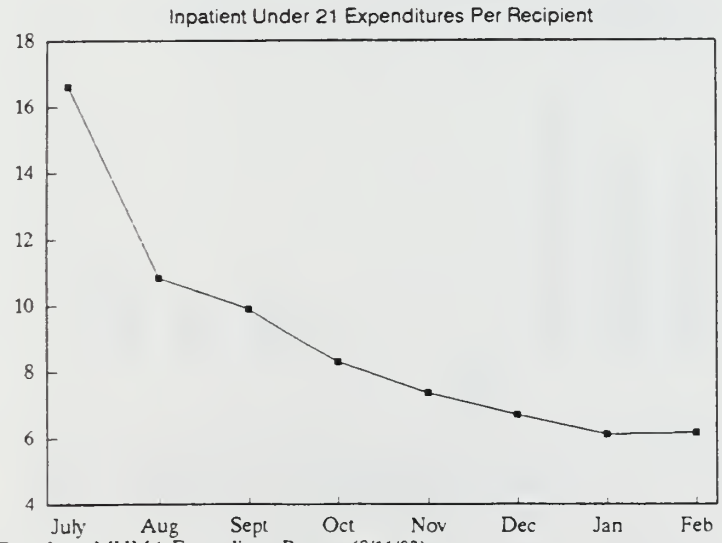
There was a clear trend of decreased expenditures per recipient for inpatient hospitalization of adults[18] and persons under 21, psychiatric services, and outpatient mental health care.[19] The trend toward reduced clinic treatment per recipient was highly variable, and no trend was readily apparent. The reporting for mental health clinic medication and consultation were sufficiently unreliable as to preclude any conclusions about trends.[20] The only service experiencing a clear increase in expenditures per recipient was acute residential services for children, which came on line in October 1992. However, preliminary data shows a declining amount spent on these services per MHMA recipient shortly after these services came on line.



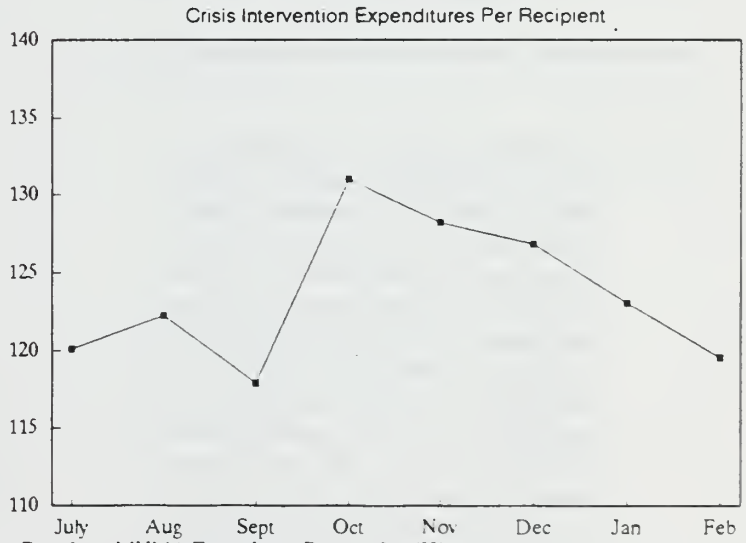
Data from MHMA Expenditure Report (8/11/93).



Total outpatient services: psychiatric, psychological, community health center, outpatient mental health, and mental health clinic services.



Data from MHMA Expenditure Report (8/11/93).



Data from MHMA Expenditure Report (8/11/93).

expenditures per recipient was present, though less dramatic, for psychological services, community health centers, and mental health clinic evaluation. The trend in spending for crisis intervention was less clear, particularly looking at preliminary data for the second quarter of calendar year 1993, which indicates a return to the higher October 1992 spending levels. Likewise, no clear trend is present in spending for psych day programs, although the spending per recipient appears to be fairly steady according to the same preliminary data. Spending for mental health

Recidivism

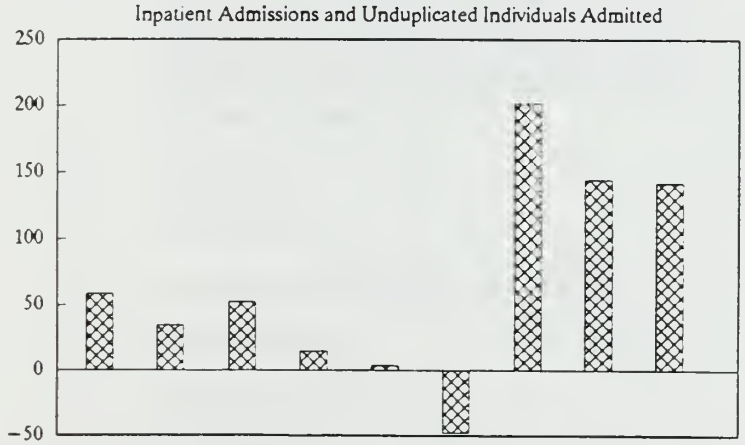
Both providers and the Alliance for the Mental Ill, a group that advocates for the families of persons who are mentally ill, perceive an increase in recidivism. A DPW survey of 11 hospitals specializing in children/adolescent treatment provided reasons for this recidivism from shorter lengths of stay to increased severity of illness. Other reasons included aftercare placement of children in

situations without the necessary structure and intensity of care, and interim placement of children at such facilities as Department of Social Services (DSS) shelters and short-term Department of Mental Health (DMH) residences. The hospitals complained that managed care has resulted in the discharge of children after the acute stage of their illness subsides, even if no appropriate placement is available.[21]

Information that MHMA has submitted to DPW on recidivism is sparse and somewhat contradictory. Thus far, MHMA only has provided recidivism data for two time periods in 1992: July through September and October through December. During these time periods the data suggests that recidivism has increased significantly for adults, increased slightly for children, and dropped for adolescents.[22] Recidivism is measured in this instance by the number of people experiencing multiple discharges during the relevant period.

The increase in repeat discharges for adults is particularly notable given the drop in the number of inpatient admissions of adults during the same period.[23] Thus the drop in the number of individual recipients being hospitalized is even larger than the drop in the number of admissions would indicate. The percent of persons experiencing multiple discharges jumped from 13.5 to 18.14%. Two adults experienced five discharges within the latter three-month period, 15 adults experienced four discharges, and 46 adults experienced three discharges.[24]

Recidivism: Difference Between Number of Adult Inpatient Admissions and Unduplicated Individuals Admitted



Negative number may be due to difference in timing/data collection methods of sources.
Source of Admissions: MHMA Monthly Report (6/15/93)
Source of Individuals Admitted: MHMA Expenditure Report (8/11/93)

The information with respect to children is inconclusive. It is unclear whether the essentially stable recidivism rate for children reflects a successful treatment strategy or the repeated direction of these children into acute residential facilities,[25] which are not part of the recidivism statistics. The available statistics show a decrease in the percent of children readmitted to hospitals or residential facilities, but show an increase in the number of children placed in inpatient settings.[26]

Preliminary numbers indicate that readmission rates for substance abuse services between July and December 1992 remained steady.[27] More recent data on readmissions is unavailable. Combined admissions (Levels III and IV and acute residential substance abuse services) have increased from about 720 in October 1992 to over 1000 in May 1993.[28] The actual number of persons served during this time period decreased from 375 to 316.[29]

Dumping?

Is MHMA dumping its "violent" acute or chronic clients onto DMH, hence making their performance look good but forcing the Commonwealth to pick up more mental health costs? Medicaid pays for DMH replacement beds[30] in private hospitals.[31] Medicaid does not pay for these beds through MHMA, but rather its fee-for-service program. If MHMA successfully veers clients to either state hospitals or to DMH replacement beds, MHMA appears to be saving the state more money than it actually does.[32]

Under an agreement between DMH and MHMA, forensic referrals go to DMH.[33] If a recipient is not the subject of a forensic referral, and the emergency screening team determines that the recipient meets inpatient admissions criteria and can not be diverted to other services, the recipient is admitted to a MHMA bed if "appropriate" and a bed is available. If a bed is not available, the client will be maintained temporarily with emergency services. If this option is not safe, the client will be admitted to a DMH-funded bed and transferred to an MHMA bed as soon as one is located.

The criteria state that a recipient is not appropriate for a MHMA bed if:

> The recipient is exhibiting psychiatric symptoms and/or behaviors that are severely aggressive and violent (suicidal included) and require an extraordinarily intensive level of staffing and security to safely administer effective psychiatric interventions. This must be determined by a DMH designated psychiatrist. When recipient is no longer exhibiting these symptoms, he is to be transferred to an MHMA bed. (Note: MHMA bed should be read as private or general hospital bed, which could include the use of free care.)
>
> The recipient has been discharged within 90 days from a DMH inpatient facility. Patient will be readmitted to the same facility.[34]

Not only may initial admissions that are extremely violent be veered to DMH, but also other "problematic" recipients currently under MHMA care may be transferred

continued on page 30...

26. This dual tracked process is the result of negotiations between Cambridge and mental health law advocates.

27. The Metro-Boston Area Office often returns authority to address complaints to the Center Directors, the heads of the facilities in the area. One reason for this practice may be that the Metro-Boston area now contains the Cambridge/Somerville service area, which was previously a distinct DMH Area Office. Other reasons may include the large number of facilities in the area, the strength of the Center Directors, and a history of delegating responsibility for complaints.

28. This arrangement raises additional questions regarding whether the HRC is acting within its appropriate role. The function of a facility HRC with respect to complaints and investigations is detailed at 104 CMR 24.11. The HRC is established to protect the rights of clients by investigating complaints and allegations of client mistreatment, harm or other violations of rights. To do so, the HRC may file its own complaints, assist incapable clients in filing complaints, and review all complaints filed so as to keep aware of consumer concerns.

29. Similarly, senior staff at Providence will likely oversee other steps of the complaint process at Charles River West. The decision regarding appointment of the investigator will likely be made jointly by staff at Providence and Charles River West.

30. In at least one case at Westwood Lodge, this process has permitted the HRO, who is also the COO, to screen out an oral complaint alleging serious abuse. An investigation was finally conducted after the complainant wrote to the Chief Executive Officer explaining that his complaint had not been responded to in many months.

31. McLean has both a Patient Advocate and a Civil Rights Officer. The Patient Advocate addresses all complaints except those handled by the Civil Rights Officer, who deals exclusively with patients' civil rights. For the purposes of this article, only the complaint process involving the Patient Advocate was examined.

32. 104 CMR 24.04.

33. 104 CMR 24.03 (4).

34. 104 CMR 24.03 (20); definitions at 104 CMR 24.02.

35. 104 CMR 24.04 (1).

36. 104 CMR 24.04 (2).

37. 104 CMR 24.05.

38. 104 CMR 24.05 (4)(a).

39. At all the DMH facilities considered, the complainant may receive a copy of the investigation report.

40. The DMH replacement units considered have differing policies with respect to whether complainants have access to the investigation report. At Deaconess, they may receive a copy. At AtlantiCare, the COO thought complainants probably could not receive a copy. At Cambridge, they may not. At Charles River West, the issue is not yet decided.

41. At the DMH licensed units considered, complainants generally do not have access to the investigation report. At Arbour, McLean, HRI and Westwood Lodge, complainants cannot receive the report. At Bournewood, the Patient Advocate was unsure if complainants would have access.

42. When complaints about licensed units are brought to the attention of DMH's Division of Licensing, the DMH Director of Licensing will review them, under the aegis of DMH licensing authority. The Director will review the complaint and decide whether it requires DMH investigation. If so, the Director could request an investigation by a DMH Internal Affairs investigator. The Director of Licensing, the DMH Deputy Commissioner for Clinical and Professional Services, or the DMH Commissioner will write the decision letter. No formal policy or procedure exists providing a more detailed description of this Division of Licensing complaint process.

43. 104 CMR 24.05 (4).

44. 104 CMR 24.05-24.07. While 104 CMR 24.06 states that first level appeals be sent to the "Chief Operating Officer or designee," DMH Memo #86-6 *Handling of Investigation Appeals per 104 CMR 24.06(2)(b)* indicates that such appeals should be sent to the Deputy Commissioner.

45. McLean Hospital, *Patient/Family Complaint Policy and Procedure*, effective April 1, 1988; revised 1992.

46. Arbour Hospital, *Patient Complaint Policy and Procedure*, effective January 1988; revised July 1992.

47. For example, while utilizing an independent investigator is a legal requirement and an essential element of the DMH complaint process, her appointment does not always guarantee a complete and impartial investigation. Recently, the DMH Deputy Commissioner of Program Operations ordered a reinvestigation into a complaint originally investigated by a DMH Internal Affairs investigator after that investigator apparently missed important and relevant testimony.

48. Legislation (H. 4957), presently before the House Ways and Means Committee after being reported favorably out of the Joint Committee for Human Services and Elderly Affairs, would require DMH replacement units to comply with DMH regulations regarding the reporting, investigation, and resolution of claims of abuse, as well as other illegal, inhumane and dangerous conditions and incidents.

Managed Care *continued from page 17...*

to DMH. A transfer from MHMA to DMH will occur[35] if criteria A through C are met and at least one from 1 through 4:

A. The recipient is a substantial risk of harm to self or others without 24 hour medical supervision and treatment, and

B. Despite adequate treatment (length, aggressivity, and multidisciplinary nature), the recipient remains markedly impaired and can not be transitioned to community setting without extended inpatient rehabilitation, or

C. The recipient is markedly impaired psychiatrically and, according to inpatient assessment, will need intermediate or continuing inpatient treatment of substantial length.

and:

1. Recipient's medical condition prevents aggressive treatment within 30 days; or

2. Recipient needs specific community-based treatment service that is unavailable in a reasonable amount of time or before the recipient would be rehospitalized; or

3. Good faith efforts to reintegrate the recipient back to community have repeatedly failed or to do so would be unsafe; or

4. Insurance benefits have been terminated and all avenues of appeal have been exhausted where there was a question as to the clinical basis for the termination.

James Michel, DPW Manager of the Mental Health/Substance Abuse Program, hails the protocols for delineating the areas of responsibility for each agency. He asserts that dumping is not a problem, noting that MHMA inpatient admissions jumped in January 1993 and stayed there through April.[36] MHMA's expenditure reports show a dramatic drop in expenditures for inpatient admissions, but only a slight drop in the number of disabled adult recipients receiving inpatient hospital care between July 1992 and February 1993.[37]

Other potential increases in DMH costs due to MHMA cost-cutting strategy could result from MHMA plans to generally limit use of day treatment programs to one year. Thereafter, MHMA plans to direct recipients to DMH-funded clubhouses.

Outpatient[38] protocols

While MHMA seems to think its outpatient protocols are generous, others may think differently. For example, if a person suffers from sexual dysfunction and attends individual therapy one hour per week, he or she has two and a half months to "shape up" because, without special approval, no further services will be provided.[39] If a person with pyromania or kleptomania undergoes the same treatment regimen, he or she has three months to resolve any underlying issues.[40]

In addition to the aforementioned limitations on some outpatient treatment, care is further proscribed by requiring the client to be motivated, engaged or willing to comply with the treatment plan and to be making progress toward treatment goals.[41] As a preponderance of practitioners will agree, clients most in need of service often attend therapy erratically and experience plateaus in their treatment progress.

MHMA divides outpatient treatment into three stages -- acute, active and maintenance -- and establishes guidelines for treatment that do not require special approval. The following table shows the range of permissible hours of individual therapy that may be requested for specified periods of time.

Acute	Active	Maintenance
Up to 4 Weeks	*Up to 26 Weeks*	*Indefinite* (may be submitted for up to a six- month period)
4 to 12 hours during maximum of 4 weeks	*6 to 26 hours* during maximum of 26 weeks	*0 to 2 hours* per month

MHMA clearly favors group therapy, regardless of circumstances. It is seeking to increase the use of group therapy by allowing the substitution of two 90 minute group sessions for a single hour of individual therapy.[42]

New Services

There is some good news regarding new services now or soon to be available to MHMA recipients. One of these new services is called the Family Stabilization Team. MHMA anticipates that the team will provide intense family support services for the first month following the inpatient discharge of a family member, with those services tapering off for the next two months. One or two of these teams will be available in each of MHMA's six regions.[43] The teams were to be phased in starting June 1, 1993, with rolling implementation throughout the summer. As of late July, seven families used the services.[44]

Adult Partial Hospitalization programs also are being solicited.[45] Adult Partial Hospitalization consists of

a six hour treatment day, seven days a week, with the person staying in the community. Only those Adult Partial Hospitalization programs associated with network hospitals are being seriously considered. Rationale: continuity of care. Since these programs are a step down from inpatient hospitalization or an observation bed, MHMA asserts transition from inpatient status may be easier in that the same social worker and psychiatrist could be available to the consumer. Similar programs are being sought for children and adolescents.[46]

As with outpatient services, consumer advocates are concerned that new services only will be available as an alternative to inpatient hospitalization or for an artificially short period of time. For example, MHMA anticipates the use of Adult Partial Hospitalization to be no more than 14 days.[47]

Primary Inpatient Psychiatric Facilities

MHMA has adopted a policy, which if not rigidly applied, could improve quality of care by improving continuity of care. The policy, effective April 1, 1993, designates a Primary Inpatient Psychiatric Facility for each recipient. Each recipient is directed to the hospital closest to her home unless:

* the recipient expresses preference for another facility near her home; or
* it is clinically contraindicated; or
* the recipient was discharged within the past 90 days from another facility (including a DMH state or replacement bed) unless the recipient was at the other facility because a bed was unavailable at the primary facility; or
* the recipient is a child with medical complications, in which case the child will be directed to Children's Hospital.

DMH and MHMA are jointly procuring the Crisis Teams that assess the need for and location of inpatient admissions. Extended assessment, observation, holding (AOH) beds will be used when a bed is not available in the recipient's primary facility or it appears as if the recipient's symptoms may stabilize within 24 hours.

Network Size - the Day Treatment Program Conundrum

There are currently about 40 day treatment programs across the state. Although in late July, MHMA was considering reducing the number of programs in the MHMA network to 20 or 25, about 34 programs should have network contracts in September 1993.[48] Of 43 applications for network affiliation, 31 were recommended by MHMA and accepted by DPW, with three more pending for future consideration.

MHMA was considering a small number of network programs because, according to Betsy Pattullo, Executive Director of MHMA, smaller networks seem to show more interest in Medicaid clients.[49] Is this because, being more dependent upon Medicaid clients for their revenue flow, they are more sensitive to pleasing these clients (or their funding source)? According to Pattullo no, but she provided no alternative explanation.

MHMA could be more interested in a smaller network because it has more leverage with the provider if Medicaid is a higher percentage of the provider's funding. This is a mixed blessing. On the one hand, MHMA can use its leverage to reduce provider charges and cut unnecessary costs to everyone's advantage. On the other hand, providers may cut useful services rather than unnecessary costs, to maintain a profit while operating under MHMA's reduced payment schedule. Clearly, however, a smaller network is never a blessing when services are in short supply, which, as AMI noted and MHMA agreed, is the case for day treatment programs.

Quality of Care

Although MHMA has performance specifications for its providers, DPW acknowledges MHMA has not systematically monitored compliance with those specifications as of July 1993. DPW states that its goal for fiscal year 1994 is for MHMA to formally monitor its providers on a quarterly basis. The process would not necessarily involve individual meetings with providers, but rather group gatherings of different types of providers, e.g., day programs.

The performance standards hold some promise for consumers if enforced. For example, the standards require, prior to an admission to a hospital, that the attending psychiatrist evaluate the consumer's mental status and address provisional and rule out diagnoses,[50] the justification for hospital care, the proposed course of care, the tentative discharge plan, and the estimated length of stay. The treatment team must meet within 24 hours of admission to establish a provisional treatment and discharge plan.

The plan must include the treatments planned, the anticipated length of stay, a specific discharge and aftercare plan, and the staffperson responsible for implementing the discharge and aftercare plan. Treatment plans must be updated every 48 hours. For children and adults living with family members, family contact will be initiated within 24 hours of admission unless specifically clinically contraindicated. Family members must be involved in treatment sessions at least twice weekly. Initial aftercare service must be no more than five days from discharge.[51]

Less clearly advantageous to consumers are the measures by which hospitals will be judged. These are:

* *Length of stay* - variance from the pre-MHMA norm either by facility or provider within a facility

* *Average cost per case* - in relation to a regional norm

* *One/two day discharge rate* - any length of stay of one or two days not related to a person leaving against medical advice

* *Administratively necessary days* - the percentage of costs due to administratively necessary days

* *Six month readmission rate*

* *Against Medical Advice discharge rate*

* *Serious incident rate* - suicide attempts, elopement, serious medical complications

* *Aftercare follow-up rate*

* *Patient/family satisfaction scores* - quarterly mean satisfaction scores at "good" or above

The key to quality assurance will be whether factors like the average cost per case will hold more weight in facility evaluations than patient satisfaction scores.

Profits Notable

Between July 1992 and March 1993, MHMA has spent an average of $571 thousand a month less for services than provided for in DPW capitated payments to MHMA.[52] From July through December of 1992, MHMA realized a profit due to an incentive payment for a reduction of inpatient admissions of $300,000. Between January 1993 and March 1993, MHMA realized a profit on reduced expenditures of approximately $235 thousand. Extrapolating these profits over the rest of the year, MHMA will earn over $770 thousand, which is in addition to the administrative payments it receives from DPW. Outside of the first few months of operations, the ledger had always been positive.

Is the state saving money? Maybe. According to Michel, DPW paid $184 million for mental health and substance abuse services to the managed care eligible population during fiscal year 1992. In fiscal year 1993,[53] DPW paid MHMA slightly over $159.5 million for services only.[54] MHMA spent less than that amount on services, with the amount of savings attributable to DPW being slightly over $12.7 million dollars.[55] Adding the MHMA administrative expenditures for the year[56] (almost $11.7 million dollars) plus the Paramax payments[57] (almost $2 million dollars), the program for fiscal year 1993 cost about $160.5 million. The substantial savings on services -- $37 million -- being offset by higher administrative costs.

Should we care if MHMA earns a bundle if the state saves money? Yes. Not only is quality of care a concern, but the allocation of societal resources is also at stake, even if those resources are not directly distributed by the government. Is it reasonable that scarce health care dollars are spent to aggrandize the bottom line of a Tennessee subsidiary of a Virginia corporation? And if so, just how many dollars are reasonable? DPW pays MHMA approximately $1 million[58] each month to administer the program.[59] In addition to the administrative portion of DPW payments to MHMA each month, DPW pays Paramax almost $150,000 to pay MHMA. Extrapolating these amounts through the rest of calendar year 1993, this puts administrative costs of this program at over $14 million.

Is it possible for the government to directly administer the same type of managed care program for less money? MHMA has about 120 employees locally, with executives being paid in the $80,000 range. Some of the $14 million earmarked for administration goes to profit.[60] According to the MHMA's bid for the DPW contract, 15% of its administrative budget is for profit and another 26% goes to its parent company.[61] The government could eliminate the portion of administrative payments going to profit and conceivably deliver comparable management services at a lower cost.

If it is possible for the government to deliver the administrative services of MHMA for a lower cost, the government should do it. The DPW should learn what it can from the MHMA experience and effect the positive lessons. Precious few dollars are allocated for public health care. These dollars should be spent for services, not for profit.

DPW Payments to MHMA in FY 93
Not Attributable to Mental Health/Substance Abuse Services

Profit	Administration
$770,000	$11,687,000
Total Non-Service Payments to MHMA: **$12.46 million**	

ENDNOTES

1. Mental Health Management of America (MHMA) began screening requests for inpatient hospitalization in April 1992. It began managing outpatient care in July 1992. In October 1992, inpatient care (except for emergencies) was limited to hospitals that are part of the MHMA network. In January 1993, outpatient care was similarly limited to network providers. *See*, Fendell, *Managed Care in the Medicaid Mental Health System: Verdict Out, Concerns Abound*, Advisor, March 1993, at 10.

2. A diversion occurs when modification of the treatment plan results in a change in the type of service provided.

3. DPW letter to MHLAC (July 21, 1993).

4. Child/Adolescent Inpatient Provider Survey - July 22, 1993 draft.

5. 104 C.M.R. § 450.124(H)(1)(b).

6. July 1992 through May 1993. MHMA Monthly Report (June 15, 1993).

7. Either clients or providers can call (800) 998-6462 to debate a decision with MHMA.

8. Both informal reconsideration and informal appeal are internal MHMA procedures. The difference between reconsideration and appeal is that a reconsideration is performed by the same person who made the decision being questioned, while an appeal is reviewed by another employee of MHMA who was not a party to the original decision. Appeals usually (though not always) follow a negative decision on reconsideration.

9. DPW has not tracked outpatient services in terms of services requested, approved, or denied. DPW letter to MHLAC (July 21, 1993).

10. The more admissions per recipient, the higher the recidivism rate. Therefore, if the same number of recipients are receiving hospital services, but more admissions to hospitals are being recorded, the same recipients must be getting more services as a result of a higher rate of recidivism.

11. As noted in the March 1993 Advisor, consumer advocates generally applaud the decrease in hospitalization of persons with mental illness. However, sufficient alternatives and access to outpatient care are vital to a sound system of mental health care.

12. Level IV care is a hospital level of care that is medically managed. Level III care is medically monitored care, usually provided by free-standing detoxification facilities or by hospitals at a lower cost than Level IV care. Acute residential services are post-detoxification rehabilitative services.

13. Between October 1992 and May 1993, the changes in admissions to the aforementioned substance abuse services were:

	Oct.	May	Change
Level IV	174	58	- 67%
Level III	430	642	+ 49%
Acute residential	99	260	+163%

MHMA Monthly Report (June 15, 1993).

14. MHMA Discharge Planning Survey (undated).

15. Although February is a relatively short month, which would lead to lower expenditures overall, data for both January and March show decreases in expenditures per recipient, the only exceptions being crisis intervention and mental health clinic treatment. MHMA Expenditure Report (Aug. 11, 1993).

16. February 1993 was chosen as the last accurate month for data, as providers have up to 90 days to submit bills for services. The earliest report used was run at the end of June 1993.

17. MHMA Expenditure Report (Aug. 11, 1993). According to the June 29, 1993 MHMA Expenditure Report, the number of male recipients served increased by 49%, while the number of female recipient increased by 34%. The only age group that did not see an increase in the number served was that of persons aged 65 and older. It should be noted, however, that this group always comprised an extremely small percent of those served (never more than 24 persons), because persons in this age bracket are supposed to be covered by Medicaid's fee-for-service program, not MHMA.

18. Rate concessions constitute the most significant factor in reduced expenditures per recipient for inpatient care for adults.

19. The term outpatient mental health care in the context of this portion of the article refers to outpatient programs of hospitals. The definition of other terms used in this section are based on their meaning in MHMA expenditure reports:

Psychiatric services: any services billed by a psychiatrist under her own vendor number.

Psychological services: testing only.

Community Health Center: any services billed by a community health center.

Mental health clinic consultation: discussions between mental health clinic personnel and another provider concerning a recipient.

20. Between the June 1993 and August 1993 expenditure reports, the number of unduplicated recipients doubled, tripled, and quadrupled over the number of previously reported unduplicated recipients for the same time periods.

21. Child/Adolescent Inpatient Provider Survey - July 22, 1993 draft.

22. July 21, 1993 DPW response to Freedom of Information Act request (discharge report).

23. MHMA monthly report dated June 15, 1993. Total adult inpatient admissions were 649 in July 1992 and 524 in December 1992.

24. July 21, 1993 DPW response to Freedom of Information Act request (discharge report).

25. Acute residential facilities for children provide short-term diagnosis, stabilization and treatment services in a 24-hour staffed, non-hospital residential setting. Length of stay ranges from one to 14 days. MHMA, *A Plan for the Procurement of Diversionary Services for the Medicaid Mental Health and Substance Abuse Managed Care Program* (undated).

26. July 21, 1993 DPW response to Freedom of Information Act request (discharge report); MHMA Expenditure Report (Aug. 11, 1993).

27. July 21, 1993 DPW response to Freedom of Information Act request (discharge report).

28. MHMA Monthly Report (June 15, 1993).

29. MHMA Expenditure Report (Aug. 11, 1993).

30. DMH replacement beds "replace" inpatient capacity formerly provided by state hospitals.

31. DMH replacement beds increase the overall amount Medicaid pays for hospital stays, but has the potential to lower what the state pays overall for hospitalization due to federal matching funds.

32. On the other hand, one DPW official feared DMH would attempt to direct consumers to MHMA as DMH decreases its capacity and faces a reduced budget.

33. DMH/DPW(Medicaid)/MHMA Interagency Agreement Regarding Clinical Criteria and Protocols (April 1993).

34. MHMA agreed to do the same for its recipients, as long as the recipient is still Medicaid eligible and not in need of long-term care.

35. If DMH refuses to admit or accept the transfer of a recipient, MHMA can appeal this decision to the DMH area director or her designee. The appeal process is expected to be completed within three working days.

36. Some think DMH should get out of the acute care business (except for the uninsured) and spend its resources on other long-term care like rehabilitation services and residential settings. A survey of hospitals in January and February 1993 supports this prioritization of DMH resources. Most hospitals thought that the lack of housing options was the greatest impediment to discharge from mental health hospitals. MHMA Discharge Planning Survey (undated).

37. MHMA Expenditure Report (Aug. 11, 1993). In comparison, the number of non-disabled adult recipients who received hospital care decreased by 10% between July 1992 and February 1993, and expenditures for that care decreased by 56%.

38. As of the end of July 1993, there were 192 mental health clinics with MHMA contracts, 37 of which are based in the Boston area. Almost a quarter of the 192 contracts are with clinics that have a family or child orientation.

39. The guidelines allow a maximum of 4 hours of individual therapy for up to four weeks during the acute phase and up to an additional 6 hours during the next 26 weeks (the active phase). No further therapeutic services are offered under the outpatient protocols.

40. Outpatient Treatment Protocols (June 24, 1993). Michel asserts that the guidelines are normative good practice and that years of inappropriate weekly therapy is detrimental because it creates a false impression that the recipient is being helped.

41. *Id.*

42. *Id.*

43. Metro Boston Community Services Network is the Family Stabilization Team for Boston.

44. DPW letter to MHLAC (July 21, 1993).

45. MHMA plans to contract with 15 to 20 programs throughout Massachusetts. Application for Network Affiliation for Partial Hospitalization (May 7, 1993).

46. The procurement process was not complete as of late July, although the application deadline was June 4, 1993. DPW letter to MHLAC, date July 21, 1993; Application for Network Affiliation for Partial Hospitalization for Children and Adolescents.

47. Application for Network Affiliation for Partial Hospitalization, May 7, 1993.

48. Day treatment program services are available to MHMA recipients prior to contract completion as non-network services.

49. Originally, Pattullo claimed a reduction in network programs would be partially due to quality considerations, but primarily due to the drop in utilization of services as long-term consumers are directed to DMH-funded clubhouses. Pattullo inferred that decreased utilization means that MHMA requires less programs to meet its needs. However, she modified her explanation when challenged that MHMA should not care how many programs are in the network since it reimburses on a per capita basis.

50. A provisional diagnosis is a temporary diagnosis made pending further evaluation and/or observation. A rule out diagnosis is an alternative diagnosis that must be "ruled out" prior to a definitive diagnosis being made.

51. Mental Health/Substance Abuse Managed Care Program, Policies and Procedures, Sections 5.02 et seq Beginning April 1, 1993, hospitals and Level IV providers must provide MHMA with an aftercare plan two days before the discharge of a recipient. An MHMA utilization review clinician reviews the plan. If approved, the plan is discussed with the recipient and her family, primarily to inform her of the details of the plan (e.g., appointment times), and with aftercare providers. The recipient is supposed to sign the plan. The MHMA utilization review clinician reviews the final plan for approval. The inpatient provider forwards this plan to the aftercare providers, who then are not required to seek prior authorization for the services outlined in the plan.

52. MHMA is paid a capitated rate that is divided into a portion for service and a portion for administration.

53. Using the first nine months of fiscal year 1993 and extrapolating out for the whole fiscal year.

54. Figure calculated by multiplying claims figures on untitled DPW buckets report dated June 15, 1993 by appropriate capitated rate for service for July 1992 through March 1993. Amount for April through June 1993 based on 1993 first quarter experience.

The rates for July to December 1992 were renegotiated in November 1992. The rates for January through December 1993 were renegotiated in June 1993. The rate used herein is the latest negotiated rate:

1992 Disabled:
$ 97.81 service and $7.14 administration
1993 Disabled:
$107.69 service and $5.16 administration

1992 Other:
$24.64 service and $2.13 administration
1993 Other:
$20.80 service and $1.63 administration

55. Figure of savings arrived at by subtracting expenditures in expenditure report from figure calculated in above footnote and multiplying the remainder by .92, the amount of each dollar saving or loss borne by the DPW.

56. Figure arrived at by multiplying claims in DPW untitled buckets report dated 6/15/93 by appropriate capitated rate for administration. See note 54, *supra*.

57. Paramax is a private company that processes Medicaid payments to providers and MHMA.

58. Figure derived from dividing administrative payments from July 1992 through March 1993 by nine.

59. In 1991, DPW paid Paramax about $771,000 to process claims.

60. Unfortunately, MHMA does not have to report its administrative expenses to DPW.

61. MHMA, A Budgetary Proposal to the Department of Public Welfare, Commonwealth of Massachusetts to Manage the Medicaid Mental Health and Substance Abuse Managed Care Program (undated).

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Mental Health Managed Care: MHMA Report Card Mixed Conflict Between Profits and Consumers

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The Executive Office of Health and Human Services' Division of Medical Assistance[1] (DMA) is seeking to extend its existing waiver of federal Medicaid requirements, hoping to continue its experiment with the private management of mental health services in Massachusetts. In anticipation of the requirements for obtaining a continuance of the existing waiver, the Department of Public Welfare retained Brandeis University's Heller School for Advanced Studies in Social Welfare to review the results of its test to date. The Brandeis Report,[2] issued January 24, 1994, discusses cost savings and provider perceptions of the program,[3] but the evaluators lacked data needed to address consumer satisfaction with the performance of Mental Health Management of America (MHMA), the private company hired to administer the program. The lack of data on consumer satisfaction indicates the limited influence and participation of consumers in the MHMA system and in their own treatment.

This article examines the lack of consumer input and the reasons for that deficit, as well as several trends and new developments associated with managed mental health care, some of which are quite positive. The article also will scrutinize the savings purported to be achieved by MHMA and questions DMA's plans to pay MHMA more for the administration of the program.

Brandeis Report

Consumer Satisfaction

The Brandeis Report provided no reliable information on the level of consumer satisfaction with MHMA's management of Medicaid mental health services. The Brandeis evaluation team did not conduct any consumer surveys.[4] The report questioned the validity of the pilot consumer survey conducted by MHMA and declared that "there has been a serious lag in implementing the assessment of client satisfaction."[5]

This lack of attention to consumer satisfaction demonstrates the general lack of consumer involvement in care decisions under the current Medicaid managed care system. Consumers are not notified when their providers change their course of treatment due to directives from MHMA.[6] Consumers are only given notice if a provider refuses to accept MHMA's treatment modifications.

Financial disincentives inhibit provider challenges of MHMA treatment decisions. Not only does MHMA have the ability to limit referrals to a particular provider, but MHMA also has the authority to exclude any particular provider from the network altogether. Off the record, medical professionals at hospitals and clinics report fear of retaliation for direct or indirect criticism of MHMA.[7] Without notice from either MHMA, DMA, or their caregivers as to treatment modifications, consumers are unlikely to learn of MHMA-inspired treatment changes and may be left out of the treatment planning process altogether.

Consumers also are excluded from the larger question of how the Medicaid managed care system should be implemented. Meaningful consumer input into quality of care assessments is unlikely in the near future. For example, an instrument that allows consumers to self-report on the effectiveness of treatment[8] is being developed through monthly meetings of a consortium of managed care organizations and other providers.[9] It is unlikely to be completed before the end of the year.[10]

MHMA is making other attempts to include consumers in the shaping of the program, although these attempts may end up being more public relations than actual inclusion. MHMA's future plans for monitoring quality of care include measurement of recipient satisfaction.[11] A plan for administering and surveying consumers on a twice yearly basis is projected to be done no sooner than July 1994.[12]

"Access" to Care

Given the shortage of consumer-centered data, the Brandeis team was forced to rely upon surrogates to divine quality of care under MHMA management.[13] One of the surrogates used by Brandeis was a measurement of access to care. According to the report, the number of inpatient providers paid by Medicaid dropped from 143 to 125 under MHMA,[14] while the number of Medicaid-eligible providers of diversionary services (e.g., respite care) increased by 20 facilities.[15]

The Brandeis report states that the slightly higher number of recipients using mental health services in fiscal year 1993 (FY93) over fiscal year 1992 (FY92) may be due to a higher share of disabled enrollees in FY93,[16] who traditionally use more services than other Medicaid recipients.[17] Furthermore, the Brandeis Report rates of use (or penetration rates) merely measure any use by a recipient and do not measure whether any continuing services were provided after the initial contact. Thus, if each recipient were to use a mental health service only one time, penetration rates would increase even though the recipients were permitted to use services only once.

Recidivism

Another surrogate measurement for quality of care used by the Brandeis team was recidivism statistics.[18] According to their research, the number of readmissions to 24-hour care per recipient declined slightly between FY92 and FY93.[19] However, when broken down between disabled and other recipients, non-disabled recipients showed more readmissions in FY93 than in FY92.[20] Brandeis attributes this to either a slight decrease in the quality of care due to substantially shorter lengths of stay

(21.8% shorter) or an approach to treatment that purposely relies on shorter and more frequent admissions.[21] Recidivism rates for non-disabled children and adolescents increased substantially during MHMA's reign — from a 6.8% to a 9.8% readmission rate within 30 days.[22]

MHMA figures on rates of readmission within 30, 60 and 90 day periods showed an increase in adult mental health readmission rates throughout FY93.[23] However, single year figures do not account for "seasonality," the theory that admission rates change during the year due to universal stressors, like winter holidays. Nevertheless, figures for children, adolescents, and substance abuse inpatient readmission rates all show different patterns,[24] facts which argue against that theory.

Provider Satisfaction

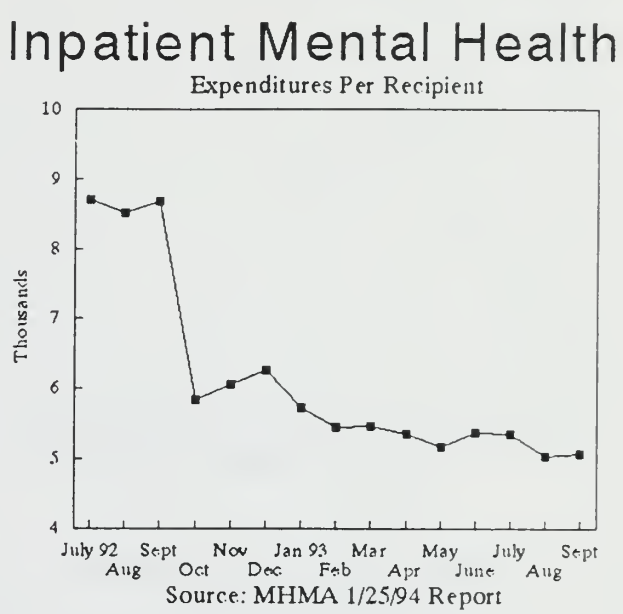
According to the Brandeis Report, providers are more displeased with the administrative burdens of MHMA managed care than with MHMA's utilization review.[25] This result perhaps can be explained by the fact that the individuals surveyed for the Report tended to occupy administrative rather than direct service positions.[26] In addition, only five percent of outpatient centers were interviewed.[27] Psychiatrists and psychologists in private practice were not surveyed at all.[28]

Of those persons surveyed, almost a quarter found MHMA utilization review decisions to be problematic, the percent being even higher for children's providers.[29] Many of the provider comments on utilization review in the appendix to the Brandeis Report were directly contradictory. For example, one provider called MHMA's clinical reviewers "excellent," while another said they were "not knowledgeable." One provider said MHMA reviewers were more flexible than other managed care groups, yet another provider said they used "a cookbook approach."[30]

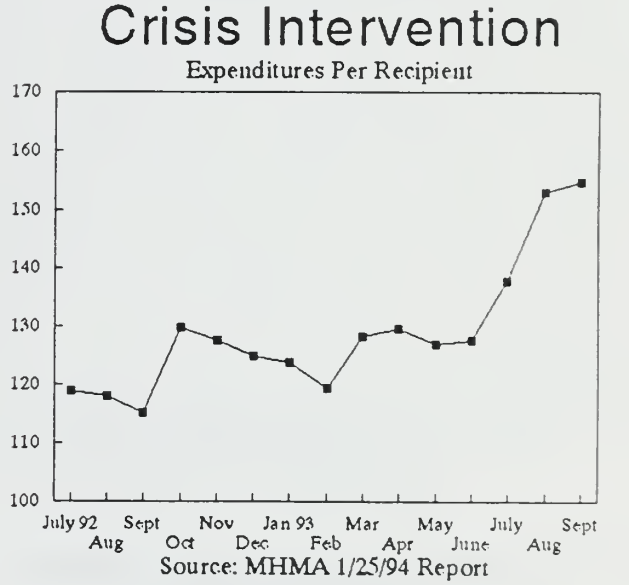
For those health care executives that find the administrative aspects of managed care to be more troublesome than the treatment issues, MHMA's move toward sub-capitation may be welcome. Under sub-capitation, providers could contract with MHMA to serve all of an enrollees' health care needs for a flat fee. MHMA has not announced when or in what form it plans to move to sub-capitation.[31] Insurers have been moving toward sub-capitation to control costs by sharing the risk with providers.[32] While sub-capitation may be cost effective by putting the provider in the role of gatekeeper, it further strains the traditional "patient/doctor" relationship. Health care providers will look even more closely at their purses while making treatment decisions. In addition, trust, an essential element of most mental health care treatment, is jeopardized.[33] As consumers become more and more conscious of the financial conflict of interest between treatment aimed at their mental well-being and the interest of providers in limiting service to increase profits, trust can dissipate.

Trends

MHMA attempts to rely on the least expensive, and hence theoretically least restrictive and intrusive, form of mental health care that it believes is appropriate.[34] Indeed, the Brandeis Report stated that of the $57 million cut in direct service expenditures (as compared to projected expenditures), $44 million was attributable to lower expenditures for 24-hour care.[35] The number of 24-hour



Source: MHMA 1/25/94 Report



Source: MHMA 1/25/94 Report

care providers reimbursed by Medicaid (both hospital and non-hospital facilities) decreased by 13% between FY92 and FY93.[36] The percent of recipients using all 24-hour care dropped by less than one-tenth of one percent,[37] while the percent of recipients using inpatient hospital mental health care dropped 2.4%.[38] Available data indicates a dramatic decline in inpatient substance abuse treatment, some decline in adult inpatient hospital mental health care, a slight increase in inpatient hospital mental health care for persons under 21, and a dramatic increase in non-hospital 24-hour care for all.[39]

MHMA significantly decreased length of stay in 24-hour facilities. For children and adolescents, average length of stay decreased by 29.8% between FY92 and FY93; for adults, by 10.3%.[40] The decrease in length of stay accounted for 12% in overall savings.[41]

Outpatient Care Declines

Outpatient expenditures were expected to rise as recipients were shifted away from inpatient services. According to the Brandeis Report this did not occur. Rather, outpatient expenditures declined by $2.8 million representing a three percent decline in the utilization and mix of services predicted without managed care.[42] MHMA itself found that a substantial number of recipients discharged from hospital units were not seen by outpatient providers "within [a] reasonable number of days of discharge."[43]

Private therapy by psychiatrists is reimbursable by Medicaid, but DMA looks askance at solo practitioners whose quality of care is difficult to monitor. Psychologists, who may not be reimbursed for therapeutic services under current law, are petitioning the legislature, the Executive Office of Health and Human Services, and MHMA, to make therapy by psychologists a reimbursable service under Medicaid. Meanwhile, community mental health centers reportedly have waiting lists for individual therapy.

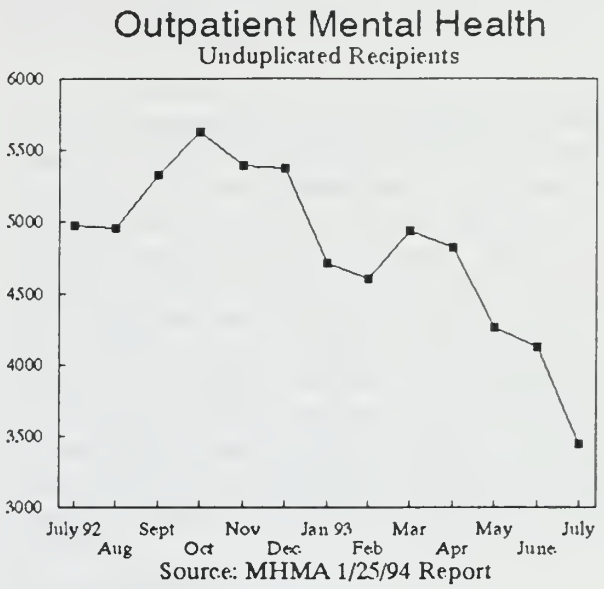
Access, as measured by Brandeis, showed the largest decline with respect to psychologists (29.6%);[44] however, this may be largely attributable to a change in how Medicaid pays (and hence measures utilization of) these professionals. In FY93, payment for psychological services to inpatients was included under facility reimbursement.[45] The decline in access to psychiatrists (12%) may be attributable to the same cause.

Change in Users per 1000 Enrollees FY92-FY93
Source: The Brandeis Report Table 2.3

Service Type	% change
Clinic Medication	29.1
Psych. Treatment	27.0
Clinic Treatment	10.6
Clinic Evaluation	4.8
Inpatient MH	-2.4
Home Care	-10.5
Community Health Ctr.	-10.5
Psychiatrists	-12.0
Crisis Intervention	-13.5
Outpatient (hospital)	-19.2
Psychologists	-29.6

Expenditures for and access to hospital outpatient services declined dramatically.[46] Other outpatient therapy services have not increased to compensate for this loss, although expenditures for mental health clinic treatment have increased slightly.[47]

The decline in outpatient services rendered by hospitals has not been fully explained. According to one DMA official, MHMA is consciously steering recipients away from hospital outpatient clinics to mental health



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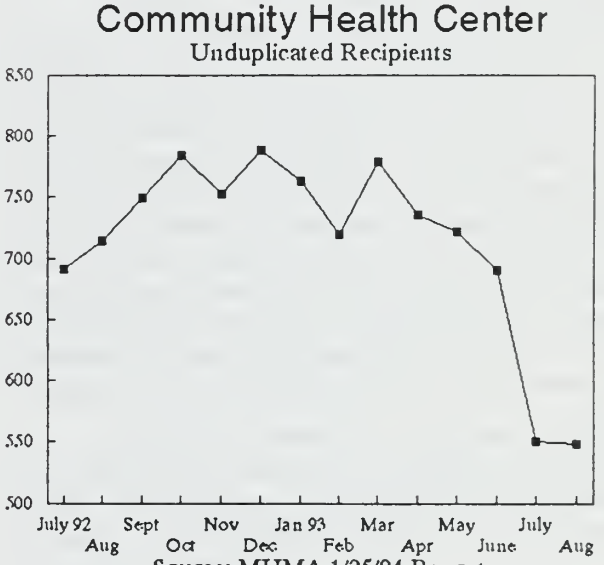

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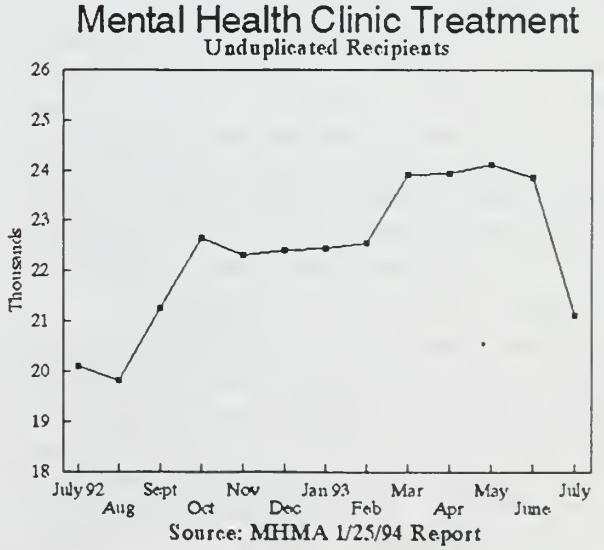
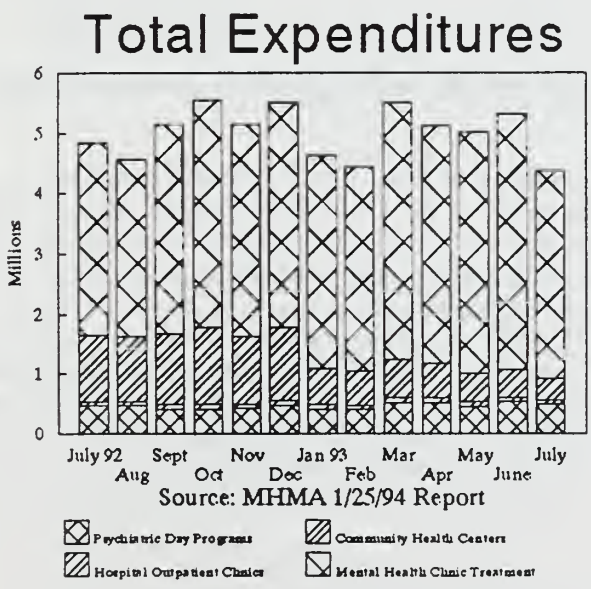


Source: MHMA 1/25/94 Report

clinics that are the more traditional caregivers to the poor. Tentative explanations have been tendered for the increase in clinic medication and psychiatric treatment. Two doctors who practice at MHMA network hospitals believe that reliance on medications has increased as the length of stay at facilities has decreased.[48] This same reliance on medication to control symptoms without treating underlying problems[49] may evidence itself in the increased use of medication on the outpatient side as well.

The Brandeis Report shows the largest increase in use for clinic medication (29.1%).[50] Recent figures show total psychiatric expenditures, expenditures per recipient, and the number of unduplicated recipients using these services dropping following the change in reimbursement methodology noted above.[51] However, the total expenditures, expenditures per recipient, and number of unduplicated recipients using mental health clinic medication have increased since July of 1992.[52]

There is a basis to fear that private managed care may lead to a decrease in outpatient care. Recently, a group of more than 100 subscribers, patients, and mental health professionals presented a demand letter to Blue Cross, the state's largest managed-care insurance company. The letter, which charges Blue Cross with violations of the Massachusetts Consumer Protection Act, described how the company threatens psychotherapists with penalties if they request too much therapy for their patients.[53] Therefore, one must look beyond denial rates and access as measured in the Brandeis Report to determine the effect of private managed care on access to outpatient services.



Holistic Dreams

Hopes that managed care can bring a more holistic approach to treatment may be warranted. According to the provider survey, both aftercare planning and case management were slightly improved.[54] Clearly, adults and children will no longer be permitted to languish in hospitals, at least not those hospitals reimbursed by MHMA. Furthermore, new services like family stabilization teams were brought on line, even if they are yet to be fully utilized.[55]

However, not all service providers believe MHMA management of care has improved treatment. About 35% of adult inpatient and 37% of child inpatient providers found case management worse than before managed care.[56] About 17% of adult inpatient and 33% of child inpatient providers thought quality of care deteriorated under MHMA managed care.[57] On the other hand, providers tend to agree that MHMA has made diversionary services available for most inpatient care, with the significant exception of substance abuse diversionary services.[58] However, even with the creation of new adult inpatient diversionary beds, most providers believe that too few diversionary beds exist for adult inpatient clientele as well as for substance abuse inpatient clientele.[59]

New Developments

MHMA has formulated children/adolescent protocols for determining when and where (in either a MHMA or Department of Mental Health facility) a child should be hospitalized.[60] Children needing acute care will not be admitted to a DMH facility. An adolescent needing acute care may only be admitted to a DMH facility if her insurance benefit is exhausted or she is uninsured and free care is not immediately available, or if she was discharged from a DMH facility within the past 90 days.[61] One positive development is that a child may not be transferred to a DMH facility solely on the basis of her refusal of treatment.[62] Where DMH and MHMA disagree as to the transfer of a child, DMH makes the final determination.[63]

MHMA recognizes that its grievance procedure is "not sufficiently useful" for handling, communicating about, or resolving "incidents".[64] MHMA will be adopting written procedures, approved by the DMA, to correct this situation.[65]

MHMA has developed a network management plan. Because "MHMA believes that resource availability drives utilization rates," MHMA will be analyzing its network capacity, focusing on 24-hour care providers and inactive outpatient providers.[66] MHMA will also be reviewing individual providers by means of a "Provider Profile"[67] (called a "Report Card" in the draft version of the plan).[68] MHMA plans to monitor "quality indicators" covering five categories: cost effectiveness, relationship with MHMA, access, comprehensiveness, and outcome.[69]

The Provider Profile compares statistics on an individual provider to the regional and state average for that type of provider. The profile will be based primarily upon claims data on admissions, cost, length of stay, and readmission. In addition to claims data, MHMA will rely upon a sample of chart reviews,[70] among other sources. Twenty-four hour services will be reviewed at least annually.[71] The six largest outpatient mental health and

substance abuse providers in each region also will be individually monitored.[72]

MHMA, as part of its quality management program, is gathering data on eight matters in 1994. The four that will be addressed first are telephone access to MHMA clinicians by providers, acute care for children and adolescents, factors associated with readmission within 30 days of discharge, and the network's capacity to serve non-English speaking recipients.[73]

Another Look at the Savings

The Brandeis Report calculated savings to the Commonwealth of $46.8 million.[74] It did this by comparing actual FY93 expenditures with *projected* expenditures. The projected expenditures were calculated using changes in the number of enrollees, changes in the mix of enrollees between disabled and other, and an anticipated inflation rate based on the Boston Medical Consumer Price Index.[75]

Sources of Savings Against Predicted Expenditures
Source: Brandeis Report Table 2.10

Indicator	Share
Price of 24-Hour Care	29%
Length of Stay	21%
Mix of Settings for 24-Hour Care	15%
Price of Ambulatory Care	13%
Number of Admissions	12%
Number and Mix of Ambulatory Services	9%

According to the report, $16.4 million in reduced expenditures for inpatient services and $2.5 million in reduced expenditures for outpatient services were due to the rates MHMA paid its providers. These changes in rates paid accounted for 42% of the savings claimed to be attributable to MHMA management.[76] Savings assessments in part depended on the Brandeis evaluators' assumption that Medicaid would not have adjusted the rates paid its providers, in particular hospital rates.[77] Given the past history of Medicaid in adjusting its rates in an attempt to lower costs, this assumption is not necessarily sound.

Reimbursement Methods Save Money

One notable source of savings has little to do with managed care, but instead with a change in the method by which hospitals are reimbursed. MHMA reversed Medicaid's 1991 decision to reimburse hospitals on a per discharge basis rather than a per diem rate.[78] According to the Brandeis Report, changes in the method of reimbursement accounts for 24% of the savings in expenditures for 24-hour care.[79] Changes in reimbursement methodology could be accomplished without managed care. MHMA included psychiatric and psychological services rendered to persons within hospital in the hospital day rate. DMA could have done the same. Likewise, MHMA negotiated lower contract rates with hospitals than DMA had paid in the past. Again, the only reason why DMA could not do this would be if the Weld administration could not stand the political heat from hospitals and professional associations opposed to reduced fees. MHMA is a convenient third party to take the wrath of unhappy constituents.

MHMA Profit

As described in prior *Advisor* articles,[80] MHMA has been paid a substantial amount of money — at least $11 million for FY93 — to administer the mental health/substance abuse portion of Medicaid.[81] The Brandeis Report calculated that administrative costs absorbed 17% of the gross savings.[82] While not all of the money that the Commonwealth has paid MHMA is profit, a significant portion is. In addition, the Brandeis Report arguably understates administrative costs by amortizing the $2.4 million administrative costs incurred in Phase I over 42 months.[83] In so doing, the Report assumes that the federal government will renew its permission to continue the experiment, and also treats payments to a private company like an investment in an asset the Commonwealth will continue to own.

The new contract with DMA will lower the amount of profit MHMA can earn from modifying service costs, but increases the amount DMA will pay MHMA for administration by about $1.8 million.[84] The additional administrative payments primarily fund 40 new positions at MHMA.[85]

Conclusion

One of the main reasons for concern about the private management of health care systems is the inherent incentive to distort care decisions to meet bottom line goals.[86] During its initial tenure in Massachusetts, MHMA certainly appears to have met its bottom line goals. What is less clear is what has happened to the quality of care for Medicaid recipients, including whether recipients have essentially been eliminated from their own treatment planning.

Public monitoring of quality of care is fraught with difficulties. MHMA only plans to share its provider-specific performance reviews individually with their network providers. This inhibits accountability to the public and could result in unequal treatment of facilities.[87]

Sub-capitation would make the review process even more difficult. However, the most distressing aspect of sub-capitation is the demise of patient care as the single most powerful force behind treatment decisions. As one psychologist said, "Providers are working for insurance companies now, not for their patients."[88] With sub-capitation, providers would be pressed to offer low rates to please insurers and managed care companies and to squeeze care even further to meet their own bottom line.

Managed care, although it promises more holistic treatment of illness, must not be structured so as to place the manager's economic interest in opposition to the provision of appropriate care. The system set up by DMA, with a private manager dependent on cutting services — or, at best, keeping them at a level that may not be adequate — to increase its profits, creates such an opposition. If MHMA enters into sub-capitation agreements with providers, that conflict of interest will only be exacerbated.

The Weld administration should consider whether it would be more efficient, both in terms of administrative costs and quality care assurance, for DMA to administer the managed care program itself. We, as taxpayers, should question increasing investments in a private company, when those same investments could be made in a publicly-owned entity dedicated to public service (such as exists today with police and fire protection) that would continue to protect the public health for years to come. Public accountability, an item lacking for the most part under the current scenario, would have a better chance of improving. Furthermore, with the element of profit removed, DMA conceivably could administer the program at a lower cost. Even if the government decides that it would prefer to spend its Medicaid dollars on private administrators, DMA should insist upon better consumer notification, meaningful consumer input into quality studies, and monitoring of consumer satisfaction.

ENDNOTES

1. Prior to July 1993, Medicaid was housed in in the Department of Public Welfare.

2. JAMES J. CALLAHAN AND DONALD S. SHEPARD, PRINCIPAL INVESTIGATORS, EVALUATION OF THE MASSACHUSETTS MEDICAID MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM (Heller School for Advanced Studies in Social Welfare, Brandeis University, Jan. 24, 1994)(hereinafter referred to as the Brandeis Report).

3. Unfortunately, the Brandeis Report often lumps together its mental health and substance abuse conclusions and does not provide the raw data that would allow more useful observation of the impact of MHMA managed care on recipients.

4. Brandeis Report at 3-24. The evaluation team met with about 20 consumers who voiced concerned about losing control over their care, having to change providers, abbreviated lengths of stay, the profit-making nature of MHMA, and other issues. The report notes that the sample is neither representative nor large enough to make generalizations. *Id.* at 3-25-26.

5. *Id.* at 3-24.

6. See Fendell, *Mental Health Managed Care: Service Expenditures Down - MHMA Profits Up*, ADVISOR, March 1993, at 14, for a more detailed discussion of notice issues.

7. Providers, who asked not to be identified, told the author that they perceive pressure to follow the treatment protocols issued by MHMA and to agree to modifications advanced by MHMA reviewers. One hospital administrator spoke of retaliation by MHMA against another provider who openly disputed MHMA's treatment decisions. See also, CONSORTIUM FOR PSYCHOTHERAPY, THE DAMAGING EFFECTS OF USING MANAGED CARE IN OUTPATIENT MENTAL HEALTH: CASE EXAMPLES SPECIFIC TO MEDICAID AND MHMA 2-3 (1994), which describes how a senior administrator at a large mental health center warned staff not to voice complaints against MHMA for fear of the loss of referrals or network affiliation.

8. The instrument currently being tested is SF-36, which is a 36 question client questionnaire that measures functioning and well-being based on client perceptions. Mental Health Management of America, Quality Management Program (March 29, 1994), at App. B.

9. *Id.* at 11.

10. *Id.* at App. B.

11. "The degree to which a recipient's expectations for service have been met or exceeded and sense of well being improved" is one of 11 measurements of quality. *Id.* at 7.

12. *Id.* at 19.

13. "The evaluation team had no direct measures of the outcome of care or the quality of care delivered during the managed care period or the year preceding managed care." Brandeis Report at 2-15.

14. *Id.* at 2-8.

15. *Id.*

16. *Id.*

17. The percent of disabled recipients increased from 14.4% to 16.1%. In 1992, disabled recipients had nine times the admission rate as compared to other recipients. *Id.* at 2-11.

18. The rate of diversions and denials also was reviewed in the Brandeis Report. However, the report concluded that the decline in the percent of provider requests diverted or denied (from 10.7 in August 1992 to 4.9 percent in June 1993) could reflect changes in the nature of provider requests as well as changes in MHMA utilization review. *Id.* at 2-9. Furthermore, if a provider agreed to a change in treatment, it would not be registered as a diversion or denial. As previously noted, providers are inclined to agree with MHMA utilization review not only due to clinical concordance, but also to maintain their association with the Medicaid mental health network.

19. *Id.* at 2-16. Again this figure includes both mental health and substance abuse readmissions.

20. Percent of readmissions within 30 days:

FY92	Disabled	25.8	Other	11.1
FY93	Disabled	22.5	Other	13.4

Id.

21. *Id.* Elizabeth Funk, Executive Director of Mental Health Corporations of Massachusetts, Inc., is a proponent of this treatment tactic.

22. *Id.* at Figure 2-10.

23. Mental Health Management of America, MHMA Readmission Rates: July, 1992 to June 1993, MHMA (Nov. 18, 1993).

Readmission Rate within	30 days	60 days	90 days
7/1/92-9/30/92	13%	22%	26%
4/1/93-6/30/93	21%	29%	34%

Id.

24. Inpatient discharges and returns to inpatient by children within 30 days ranged from 3% to 8%, ending FY93 with 6%. The 60 day figures began at 11% and ended at 8%; the 90 day figures started at 14% and ended at 10%. The adolescent rate of readmission for 30 days began and ended at 10% with a high of 12%; for 60 days, began and ended at 14% with a high of 15%; and for 90 days, began at 18% and ended at 17%. Substance abuse inpatient readmission rates were inconsistent, but ultimately seemed to decline between 3% and 6%. One should note, however, that recidivism rates for Level III detoxification and acute residential programs tended to increase slightly. *Id.*

25. The percent of requests denied or diverted has ranged from a high of 10.7% in August of 1992 to a low of 4.9% in June of 1993. Brandeis Report at Figure 2-1. It is likely that the initial high number of denials and diversions was due to an unfamiliarity with the correct submission of claims to MHMA and with the availability of alternative services. The lower June 1993 number also may reflect self-censorship on the part of providers as they became familiar with MHMA treatment protocols.

26. The clinical liaison or department coordinator was interviewed for inpatient or residential treatment facilities; the executive director of outpatient clinics was interviewed. *Id.* at 3-2. Views of direct services providers often differ from those of administrators. *See*, CONSORTIUM FOR PSYCHOTHERAPY, THE DAMAGING EFFECTS OF USING MANAGED CARE IN OUTPATIENT MENTAL HEALTH: CASE EXAMPLES SPECIFIC TO MEDICAID AND MHMA 2 (1994).

27. Brandeis Report at Table 3.1.

28. *Id.* at 3-2.

29. *Id.* at 3-5. Residential facility respondents also had a large proportion of respondents (25% to 50%) who believed services were worse than before MHMA managed care. *Id.* at 3-6. The following table shows the breakdown for adult inpatient and children inpatient services:

Assessment of MHMA Clinical Review Decisions

	Adult Inpatient	Child Inpatient
Setting	5% worse	37% worse
	66% better	13% better
After Care Planning	15% worse	38% worse
	60% better	25% better
Overall	10% worse	25% worse
	48% better	12% better

Id. at Table 3.16, 3-41-42.

30. *Id.* at C-3.

31. The forms of sub-capitation can vary. For example, MHMA may choose to contract with hospitals to provide services for enrollees for a six month period from their first admission.

32. *See*, Charles Stein, *And the Last Shall Be First*, BOSTON GLOBE, Feb. 20, 1994, at A1 and A3.

33. CONSORTIUM FOR PSYCHOTHERAPY, THE DAMAGING EFFECTS OF USING MANAGED CARE IN OUTPATIENT MENTAL HEALTH: CASE EXAMPLES SPECIFIC TO MEDICAID AND MHMA 9 (1994).

34. According to Brandeis, the number of patient days in non-hospital settings doubled from 11.6% in FY92 to 25.6% in FY93. These percents reflect the major shift from hospital-based detoxification (-61.2% users per 1,000 enrollees) to freestanding detoxification (+45.2%). Brandeis Report at 2-12 and Table 2.3.

35. *Id.* at 2-19.

36. Not only are hospitals less likely to be used for 24-hour care, but the number of hospitals paid by Medicaid and thus accessible to Medicaid recipients appear to have decreased by between 34 to 46%. *Id.* at Table 2.1.

37. *Id.* at Table 2.2.

38. *Id.* at Table 2.3.

39. *Id.* at 2-13 and Figure 2-3.

40. *Id.* at 2-13. The decrease in children's length of stay is primarily a drop in the length of stay at psychiatric hospitals; for adults it is a drop in the stay at inpatient substance abuse facilities. *Id.*

41. *Id.* at Table 2.10.

42. *Id.* at 2-19. The predicted levels of care were based in part on a trend of increased outpatient utilization of 3.9% per year. *Id.* Expenditures for outpatient care fell by 12.9% from predicted values. However, $7.3 million (7.7%) of the savings was due to the lack of inflation in the charges for these services and another $2.5 million was due to the inclusion of payments for psychiatric services, psychological evaluations, and other professional services in hospital rates. *Id.*

43. Mental Health Management of America, Quality Management Program (March 29, 1994), at 31. An MHMA examination of this problem is not expected to be complete until the end of May 1995.

44. Data on the change in the number of enrollees using services between FY92 and FY93, including the table below, is from the Brandeis Report, Table 2.3.

45. *Id.* at Table 2.3.

46. Between July 1992 and July 1993, total expenditures for hospital outpatient services declined by 66%, expenditures per unduplicated recipient declined 52%, and the number of unduplicated recipients using the service declined 31%. MHMA Expenditure Report (Jan. 25, 1994).

47. Between July 1992 and July 1993:

Psychiatric Day Programs	
Total Expenditures	+6%
Exp. per Unduplicated Recipient	-3%
# of Unduplicated Rec.	+9%
Community Health Centers	
Total Expenditures	-26%
Exp. per Unduplicated Recipient	-7%
# of Unduplicated Rec.	-20%
Mental Health Clinic Treatment	
Total Expenditures	+8%
Exp. per Unduplicated Recipient	+3%
# of Unduplicated Rec.	+5%

Id.

Access to clinic treatment (as measured by the Brandeis Report) increased 10.6% in FY93 over FY92. Brandeis Report at Table 2.3.

48. Due to fear of retaliation against their hospitals by MHMA, these practitioners declined to make these statements on the record.

49. See PETER BREGGIN, M.D., TOXIC PSYCHIATRY (1991), for a description of the negative and sometimes irreversible side effects associated with drugs used to treat the symptoms of mental illness.

50. Brandeis Report at Table 2.3.

51. MHMA Expenditure Report (Jan. 25, 1994). During the period of January through July 1993, total expenditures for psychiatric services decreased 14%, expenditures per unduplicated recipient decreased by 8% and the number of unduplicated recipients using these services decreased by 6%.

52. *Id.* Between July 1992 and September 1993, total mental health clinic medication expenditures increased by 14%, expenditures per unduplicated recipients increased by 3%, and the number of unduplicated recipients using this service increased by 10%. The trend with respect to number of recipients using mental health clinic medication was less clear than for expenditures per recipient.

53. Bass, *Consumer Group Says Blue Cross Misleads on Mental Health Care*, BOSTON GLOBE, Feb. 16, 1994, at 22.

54. The mean for aftercare planning was 3.34 and for case management, 3.22. "One" was worse, "five" was better. Brandeis Report at 3-4.

55. *See, id.* at 3-7.

56. Mean for child inpatient was 2.88. *Id.* at Table 3.7, 3-35.

57. *Id.* at Table 3.2, 3-32.

58. *Id.* at Tables 3.11 and 3.12, 3-37.

59. *Id.* at Table 3.13, 3-38.

60. Clinical Task Force, DMH/DPW (Medicaid) MHMA Interagency Agreement, "Child/Adolescent Clinic Criteria and Protocols" (Oct. 1993).

61. *Id.* at Section I.

62. *Id.* at Section IV(3).

63. *Id.* at Section VI.

64. Mental Health Management of America, Quality Management Program (March 29, 1994), at 12. "Incidents" include unusual or critical incidents, recipient grievances, provider complaints on behalf of recipients, and complaints about providers. *Id.*

65. *Id.*

66. Mental Health Management of America, Network Management Plan (March 29, 1994), at 3.

67. *Id.* at 5.

68. Mental Health Management of America, Network Management Plan, Draft (Jan. 10, 1994), at 6.

69. *Supra* note 66, at 2. "Developmental measures," such as staff turnover, may be included as relevant to the type of provider. *See, e.g., id.*, Adult Inpatient Provider Profile, at 2.

70. The provider's quality assurance team would review charts for 35 randomly selected MHMA admissions to assess compliance with MHMA specifications. MHMA would then review a sample from those 35 charts. *Id.* at 6.

71. *Id.* at 7.

72. *Id.* at 7.

73. Mental Health Management of America, Quality Management Program (March 29, 1994), at 21-30. The other areas to be studied are access to outpatient services, discharge planning and implementation following Level III and IV substance abuse treatment, variation in treatment of diagnostically similar recipients by outpatient providers, and profiles of persons with dual diagnoses (mental health and substance abuse). *Id.* at 20.

74. Brandeis Report at 2-17. Reports of large savings are important to the Weld administration, because, among other reasons, it wishes to "privatize wherever, however [it] can." *Bay State Brawl*, STATE GOVERNMENT NEWS, Feb. 1994, at 22 (quoting Steven Wilson, special assistant to the governor).

75. Brandeis Report at Table 2-6.

76. *Id.* at Table 2.10.

77. See *id.* at 2-19.

78. Per discharge reimbursement led hospitals to reduce length of stay and transfer patients to other hospitals that also would receive the full payment. *Id.* at 2-14. This resulted in a higher per day rate than under the fee for service arrangement.

79. *Id.* at 2-15.

80. Fendell, *Mental Health Managed Care: Service Expenditures Down - MHMA Profits Up*, ADVISOR, Fall 1993, at 14; Fendell, *Managed Care in the Medicaid Mental Health System: Verdict Out, Concerns Abound*, ADVISOR, March 1993, at 10.

81. In addition to the $11 million Medicaid paid to MHMA, Medicaid incurred another $1 million itself. Brandeis Report at 2-17.

82. Brandeis Report at 2-18.

83. *Id.* at F-4.

84. According to DMA at its March 30, 1994 Mental Health Advisory Council meeting, the contemplated contract would limit the amount of profit MHMA could earn to $1 million. MHMA would earn that amount by holding expenditures for mental health and substance abuse services steady. Increased administrative payments to MHMA would be included in the capitated rate for each recipient MHMA manages. In addition, the service portion of the capitated rate was increased to allow for higher contract rates to providers.

85. The new positions are mostly to implement MHMA case management for its high risk, and most expensive, recipients. See, Mental Health Management of America, Intensive Clinical Management (March 29, 1994). June Gross of the Parent/Professional Advocacy League wondered whether this was just another layer of ineffective case management for recipients who typically have case managers from other state agencies.

86. Financial self-interest certainly affects — and distorts — care decisions. Most people are willing to acknowledge this fact, particularly if the economic incentives in question are considered to be past history. For example, the Brandeis Report describes how hospitals which were reimbursed on a per discharge basis would transfer patients to another service or hospital when the patient was too ill to be discharged but neared the outer limit of the hospital's reimbursement rate. Brandeis Report at A-3.

87. One hospital representative expressed concern that MHMA standards of care, including length of stay, depended upon MHMA's payment arrangements with a hospital. He also stated that in reviewing his hospital's practices, MHMA excluded data from other network hospitals that contradicted MHMA's cost cutting conclusions.

88. Bass, *Consumer Group Says Blue Cross Misleads on Mental Health Care*, BOSTON GLOBE, Feb. 16, 1994, at 22.

Health Care Reform *continued from page 1...*

Benefit Package For Mental Health

Under the Single-Payer plan, all Americans receive coverage for all mental health services, subject to care coordination and to utilization review after 15 days of inpatient care and 20 outpatient visits per year.[10] There are no caps — annual or lifetime — on services. Pre-existing conditions are covered.

The Clinton plan severely limits mental health coverage in both scope and duration. This area is one of the few sections in the plan in which coverage is so arbitrarily restricted.[11] Mental health inpatient hospital care is limited to 30 days per year with exceptions in only two cases: if the individual is deemed a danger to himself or others or if he needs to remain in the hospital for pharmacological stabilization. In either of these cases coverage may be extended, but only for an additional 30 days. Alternatives to intensive nonresidential hospitalization, including partial hospitalization, day treatment, or crisis residential services may be substituted for inpatient care. These days are exchanged at a 2 to 1 ratio. For example, if an individual reaches his 30-day annual cap on inpatient care he may not receive any other type of alternative care. Likewise, if an individual uses 60 days of alternative care, he may not receive the 30 days of inpatient care. If intensive hospitalization alternatives are needed beyond the 60 days of covered care, the individual is required to make a staggering co-payment of $25 per day or 50% of the cost for the next 60 days. Such exorbitant costs will lead many individuals to forego needed services.

Arbitrary scope and duration restrictions exist in outpatient services as well. Outpatient psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual.[12] While this number of visits may suffice for some mental health consumers, it is too few for many others.

The limitations in mental health coverage are scheduled to be phased out of the Clinton plan by 2001 or sooner if funds permit. Absolute limits on services will apparently be replaced by "management" of benefits. Such management could either increase the quality of care or impede access to it. However, a promise is not a guarantee, and for a person with mental illness, seven years is a long wait for comprehensive mental health coverage. The wait is particularly troublesome since the infrastructure to provide most of the necessary services already exists.

Under the Clinton plan there are no lifetime caps on medically necessary services. Nor are pre-existing condition exclusions permitted.

The Cooper plan affords no mandated set of minimum benefits. A Health Care Standards Commission appointed by the President must recommend a uniform set of benefits to be offered by each accountable health plan, subject to Congressional approval. The benefits must include a "full" range of "medically-appropriate" treatments and diagnostic services. No mention is made of long-term care benefits which may or may not be included. Pre-existing condition exclusions are allowed under the plan.

Co-payments and Deductibles

The Single-Payer plan requires no co-insurance, deductibles, or co-payments for benefits. However, the plan's language leaves open a possibility of cost-sharing for long-term care services.

One of the major concerns about the Clinton plan is the unaffordable co-payment requirements.[13] Eligibility for reduced or no co-payments and deductibles is tied to receipt of cash assistance.[14] Low-income people would be asked to make the same co-payments required of enrollees with much higher incomes: $10 per physician, $5 per prescription, $25 per outpatient psychotherapy visit,[15] and $25 per non-emergency use of an emergency room. For cash assistance recipients, all but the final co-payment would be reduced by 80%. Additionally, the plan's limit on out-of-pocket costs for deductibles and co-payments of $1500 for an individual and $3000 for a family does not include the out-of-pocket costs for mental health services beyond the 30-day inpatient limit. For example, the $25 per day co-payment for intensive nonresidential hospitalization alternatives after 60 days may not be applied toward any annual out of pocket limit on cost sharing. The same exclusions apply to outpatient mental health treatment. Under the high cost-sharing plan, an individual is required to pay a 20% co-payment and there is a $200 individual/$400 family deductible.

The Cooper plan requires co-payments for all services except preventive services. No limits on co-payments are specified. Similarly, the plan places no limits on deductibles. Medicaid is eliminated. Very low-income individuals (less than 100% of poverty) are entitled to

Managed Care Update

Susan Fendell
Attorney, Mental Health Legal Advisors Committee

As Mental Health Management of America (MHMA)[1] enters its third year of managing mental health care for Medicaid recipients, certain trends in the directions of its management of services have become clearer. For example, MHMA appears to be placing greater reliance on medication of mental health consumers and on crisis intervention. On the other hand, the use of psychiatric day programs seems to be on the decline. This article highlights the trends in MHMA's service expenditures based on claims data from July 1992 through March 1994, as well as changes in the contract under which MHMA is operating.

Inpatient Services

After an initial decline in the length of hospital stays for children and adolescents, the average length of stay seems to have leveled off, judging from expenditures per recipient as of March 1994 and other data.[2] However, the average length of stay for adults appears to continue to decline, although much less dramatically than in early 1993.[3] The number of children and adults who use inpatient hospital services is at about the same level as when MHMA took over management in July 1992. MHMA began to purchase acute residential services for children in October 1992. Between that month and March 1993, the number of children using these services increased significantly.

The number of persons using crisis intervention services grew dramatically between their introduction in July 1992 and March 1993;[4] expenditures per recipient jumped to an initial high in June 1993. Both the number of users and the amount of expenditures have since been erratic though remaining in the higher ranges.[5] Additional crisis services were added in January 1994, increasing total expenditures on crisis care.

Partial hospitalization for adults, which was introduced in September 1993, has of course grown since its inception. It is unclear whether partial hospitalization will continue to grow at the same rate as during its start-up period. Already the number of recipients using the service and the expenditures per recipient are leveling off somewhat. Expenditures for partial hospitalization for children and adolescents, which was introduced at the same time, also have grown though the number of recipients using this service has dropped.

Outpatient Services

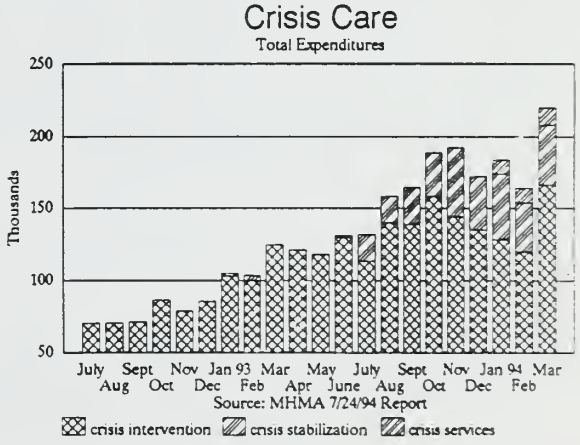
The Spring 1994 Advisor noted that, although inpatient service expenditures were being de-emphasized, outpatient expenditures declined. Since that time, outpatient expenditures appear to have stabilized. Nevertheless, particular services are favored while others appear to be discouraged.

Those clinics associated with hospitals saw about the same number of persons as in July 1992, but for far less time.[6] Expenditures per recipient dropped by almost half. Use of community health centers varied wildly, from a low of 589 recipients in August 1993 to a high of 794 recipients in March 1994. Expenditures per recipient of community health center services also fluctuated considerably, averaging $113 per recipient.[7] Mental health clinics fared somewhat better, with at least a 25% increase in recipients using services since July 1992. Expenditures per recipient remained about the same through February 1994.

Psychiatric day programs took a big hit since September 1993. The number of recipients using such services dropped about 15% between July 1992 and March 1994, and expenditures per recipient dropped over 10%.[8]

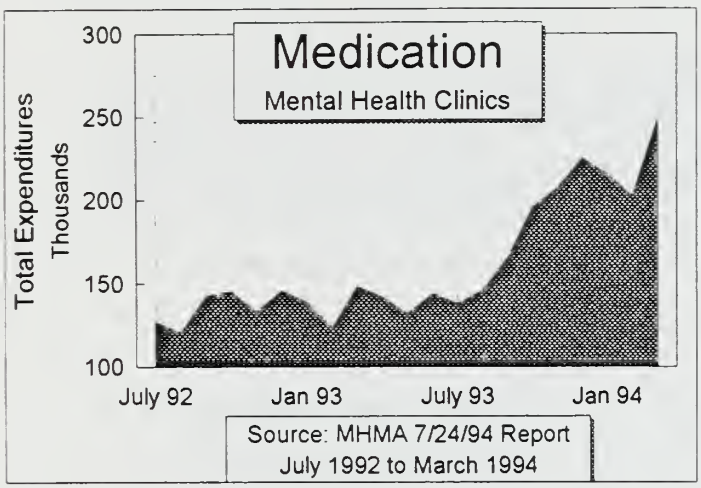
One service that increased dramatically is mental health clinic medication. An early fear of some therapists and advocates for consumers was the tendency of managed care companies to rely on the quick fix of medication rather than to pursue the longer term solution of therapy.[9] Available data confirms this fear. Both the number of recipients using medication services and the expenditures per recipient have increased significantly - by 54% and 27% respectively.

More recipients are seeing psychiatrists, approximately 14% more in March 1994 than in July 1992. Psychiatrists can either dispense medication, provide talk therapy, or both. Given the significant decrease in expenditures per recipient (about 40%), it seems likely that talk therapy is on the decline and that most persons are seeing psychiatrists for the purpose of getting medication.



More recipients and their families are utilizing family stabilization services, which were introduced in July 1993. While the expenditure per recipient dropped precipitously after its initial high in the first month, the number of users now seems to be increasing quickly, based on the limited data available.

In conclusion — which, without more information, must be tentative — inpatient services have been scaled back, with continuing tightening on the adult side forcing reliance on crisis intervention services. Outpatient services other than diversionary services have not increased to compensate for limited inpatient services. In fact, outpatient services have not changed much over time[10] - with the exception of psychiatric day programs, which are clearly being diminished, family stabilization, the users of which are increasing, and mental health clinic medication, which is flying high.



Contract Changes

The Fiscal Year (FY) 1994 contract between the Commonwealth and MHMA is notable for its increase in payments for administration and change in the financial incentives for MHMA.

Administration Payments

Payments to MHMA are made on a capitated basis.[11] The 1994 monthly rate, which is split into administrative and service components, is $94.76 for disabled recipients and $23.71 for other recipients.[12] This compares with the 1993 rates of $92.80 for disabled recipients and $25.13 for others. The direct service portion of the rate is subject to adjustment based upon actual 1993 costs, which are then multiplied by 1.04 in order to compensate for inflation and encourage "reinvestment."

The administrative portion of the 1994 rate is $6.62 for disabled recipients and $1.66 for other recipients.[13] In one year, Commonwealth payments to MHMA for administration of the program increased by 28% for disabled recipients and just under 2% for other recipients. Given the increase in enrolled recipients, administrative payments to MHMA rose almost 17% between March 1993 and March 1994.[14] Previous Advisor articles[15] questioned the wisdom of paying a private corporation to manage mental health services when it could be done by the state without an allowance for profit.[16] As the cost of administration continues to rise, the sagacity of the Commonwealth in not developing its own administrative skills is even more doubtful.

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Appeals of District Court "Mental Health" Orders

Stan Goldman
Director of Mental Health Litigation
Committee for Public Counsel Service

Matters of law arising in commitment hearings, antipsychotic medication hearings or incompetency for trial proceedings in a district court may be reviewed by the appellate division of the district courts....

As virtually all who have sought relief from apparent errors of law in district court mental health proceedings know too well, appeals under Mass. Gen. L. ch. 123, § 9(a) (quoted above) have been, for the most part, exercises in futility. The procedural maze previously established by Dist./Mun.Cts.R.Civ.P.64 made timely review by the Appellate Division of the District Court Department all but impossible. As a result, most challenges to commitment and treatment orders in recent years have been raised in the Superior Court Department pursuant to Mass Gen. L. ch. 123, § 9(b). While a"9(b)" petition will secure for one's client a *de novo* hearing as to commitability and/or treatment, it will not provide a forum in which to challenge district court errors of law.

There is now reason to hope that timely appellate review will be possible. On July 1, 1994 the new "District/Municipal Courts Rules for Appellate Division Appeal" (to be cited as "Dist./Mun.Cts.R.A.D.A.") became effective and, at least on paper, appear to hold promise. A brief outline of the procedure established under these new Rules follows. It is only an overview, however, and does not substitute for a close reading of the Rules themselves and the accompanying Commentary.[1]

Preservation of Issues for Appeal

The new Rules do not affect or alter the steps which trial counsel must take in order to properly preserve issues for appeal. Thus, for example, timely objections and offers of proof still must be made.

As before, requests for rulings of law must be made in writing prior to the commencement of closing arguments unless leave is granted to file at a later point. Dist./Mun.Cts.R.Civ.P.64A(a). Since closing arguments typically begin immediately after the close of testimony, counsel should anticipate those issues for which rulings are likely to be sought and prepare written requests accordingly. Of particular significance in a commitment proceeding will be a request for a ruling that the hospital's evidence is insufficient as a matter of law to permit

however, could be read to suggest that the court contemplated that there was no appeal from *any* action taken pursuant to section 12. See 26 F.3d at 257 n.2. On the other hand, neither the facts of *Rockwell* nor its legal analysis involve the section 12(e) procedure. Since both sections 12(e) and 9(a) describe commitments, it seems logical that an appeal could be taken from a section 12(e) ten-day commitment.

[10] *Temple*, 395 Mass. at 127-128.

[11] *See, e.g., Rohde v. Lawrence General Hospital*, 34 Mass. App. Ct. 584, 587 (1993).

[12] Mass. Gen. L. ch. 258.

[13] Physicians, qualified psychologists and police officers have immunity from civil suits for damages for "restraining, transporting, applying for the admission of or admitting any person to a facility . . ., providing said physician, qualified psychologist or police officer acts pursuant to the provisions of this chapter." Mass. Gen. L. ch. 123, § 22. See *Rockwell*, 26 F.3d at 256.

[14] *See Reida*, 36 Mass. App. Ct. at 554.

[15] *See, e.g., id.*

[16] Mass. Gen. L. ch. 258, § 2.

[17] Restatement, Second, Torts §35.

[18] *See* Mass. Gen. L. ch. 258, §2.

[19] 42 U.S.C. § 1983.

[20] *Temple*, 395 Mass. at 122, *quoting Parratt v. Taylor*, 451 U.S. 527, 535 (1981).

[21] 26 F.3d 254 (1st Cir. 1994).

[22] "In the present case, we need not decide whether the 'commitment' of a mentally disturbed person by private actors constitutes state action. Massachusetts law distinguishes between 'commitment' and 'admission' to a facility for the psychiatric care of patients." 26 F.3d at 257 n.2. While thus not explicitly deciding that ultimate issue, the First Circuit did cite to *Spencer v. Lee*, 864 F.2d 1376 (7th Cir. 1989), in which the Seventh Circuit held that a private physician and private hospital do not act under color of state law for section 1983 purposes when they commit a mentally ill individual to a hospital. *But see Moore v. Wyoming Medical Center*, 825 F.Supp. 1531, 1540-41 (D.Wyo. 1993) (relationship between county and private hospital amounted to "state action" for section 1983 purposes).

[23] *Temple*, 395 Mass. at 120, 123.

[24] *Id.* at 127. Rule 60(b) allows the court on motion to "relieve a party . . . from a final judgment, order or proceedings for", *inter alia*, mistake. Such a motion could only be made in response to an order issued by the district court pursuant to section 12(e).

[25] Mass. Gen. L. ch. 12, §§ 11H & 11I.

[26] *Id.*, § 11H.

[27] *Id.*, § 11I.

[28] *Batchelder v. Allied Stores Corp.*, 393 Mass. 819, 821 (1985).

[29] *See, e.g.*, WYO. STAT. § 25-10-109(h), (j) and (k) (1990) (court must conduct a hearing within 72 hours of the detention when an "application of involuntary hospitalization is filed").

Managed Care Update

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Incentives to Cut Modified

The contract continues to give MHMA a financial incentive to cut expenditures for services, although that incentive is clearly less motivating than in prior years. The Commonwealth pays MHMA a $1 million bonus if actual direct service costs are determined to be less than or equal to direct service payments. However, MHMA is liable for up to $1 million for any cost overruns.[17] Thus, although the incentive to cut service expenditures below their already pared level is moderated, there is still an incentive for MHMA to ensure that expenditures are kept low in order to avoid losses and to earn a million dollar bonus.

Given this incentive, the move toward subcapitation is even more disturbing. One managed care company executive counseled providers on adapting to managed care: "[S]top thinking of yourself as a provider, as an agency. CMHCs and providers have to start thinking of themselves as companies."[18] When advice like this is given to meet the demands of managed care *without* subcapitation, one can imagine the more stringent limits on care that would be placed under subcapitation.[19]

Public health should not be a matter of private profit. The Commonwealth has dedicated public employees in the Division of Medical Assistance with the capability to manage a quality mental health system if given the same resources as the Commonwealth currently gives to the private corporation it has hired.[20] Public interest, as implemented by public representatives, should govern the provision of health care.

ENDNOTES

[1] MHMA is actually First Mental Health, Inc, a Tennessee corporation that is a subsidiary of First Health Services Corporation, which in turn is a subsidiary of First Financial Management Corporation.

[2] The average length of stay for children began 1993 at 15.8 days, reached a low of 11 days in November 1993, and ended at 14 days in January 1994. MHMA Utilization Analysis Summary (May 13, 1994). The average length of stay for adolescents ranged from 15.2 to 10.8 days, ending in January 1994 at 12.5 days. *Id.* The 30-day recidivism rate for children and adolescents had jumped from 10% at the beginning of MHMA's management of mental health services to 14% during the summer of 1993. Following severe criticism by children's advocates, the recidivism rate fell to 11% as of the winter of 1994. A drop in the 30-day recidivism rate might reflect slightly longer lengths of stay in the first three months of 1994 based on expenditures per recipient which are calculated on an unduplicated recipient basis. MHMA Readmission Rates (July 18, 1994).

[3] Average length of stay dropped from 11.4 days in January 1993 to 9.3 in January 1994. MHMA Utilization Analysis Summary (May 13, 1994). The 30-day recidivism rate for adults is still higher than when MHMA began its

management of services, 19% as compared to 16%. MHMA Readmission Rates (July 18, 1994). MHMA has reduced both the 60-day and 90-day recidivism rates from their highs of 30% and 36% during the winter and spring of 1993. *Id.* The decrease in recidivism rates may be partially attributable to the increase in the use of crisis care.

[4] March 1993 is the most recent month for which reliable claims data is available. It takes approximately 90 days for the majority of claims to be filed.

[5] The number of crisis intervention users increased 33% and total expenditures increased 70% between July 1992 and February 1994. The number of users increased 70% and expenditures increased 136% as of March 1994.

[6] The average number of times recipients were seen is based upon the assumption that, outside of major changes in payment rates, a decrease in expenditures per recipient indicates fewer sessions per recipient.

[7] According to James Michel of the Division of Medical Assistance (DMA), which oversees the MHMA contract, the payment rate for outpatient treatment at community health centers is $67 per hour.

[8] Overall expenditures for pyschiatric day programs dropped 25% between July 1992 and March 1994. A DMA staffer stated that a conscious decision was made to reduce the use of these programs, partly because some programs were providing psycho-social rehabilitation rather than focused mental health care and partly because Department of Mental Health clubhouses were considered to be more appropriate for longer term care.

[9] Not everyone believes that mental illness is amenable to treatment by "talk therapy." To the extent that care managers hold this belief, decisions to rely on medication may be as much treatment based as economically based.

[10] The number of recipients who use mental health clinic, community health center, and hospital outpatient services as a percentage of total recipients under MHMA management increased from 7.3% to 7.9% between July 1992 and February 1994. Total expenditures for those services during the same time period increased less than one percent (0.5%).

[11] In addition, the contract permits MHMA to develop sub-capitation arrangements with providers upon the approval of the Division of Medical Assistance, the branch of Health & Human Services that coordinates the private management of Medicaid mental health services.

[12] Final payment is actually based on daily enrollment of recipients. The 1994 daily rate for disabled recipients is $3.12 and for other recipients is 78 cents.

[13] The administration portion of the rate can be adjusted if combined enrollment has risen or fallen by more than 10% for two consecutive months compared to expected enrollment.

[14] The number of enrolled recipients only increased 2% between March 1993 and March 1994, compared to the much larger increase in administrative payments to MHMA. Service expenditures by MHMA only increased 1.4% during the same period.

[15] Fendell, *Managed Care in the Medicaid Mental Health System: Verdict Out, Concerns Abound*, 38 Advisor 10 (1993); Fendell, *Mental Health Managed Care: Service Expenditures Down - MHMA Profits Up*, 39 Advisor 14 (1993); Fendell, *Mental Health Managed Care: MHMA Report Card Mixed - Conflict Between Profits and Consumers*, 40 Advisor 4 (1994).

[16] MHMA's administrative budget includes over $1.5 million in profit and over $2 million in payments to MHMA's parent corporation. It also includes more than $150,000 for "travel and entertainment," which is separate from the over $130,000 allotted for training.

[17] MHMA's ability to earn money is greater than its danger of losing money. MHMA is only liable for 25% of every excess dollar up to $4 million, resulting in a maximum risk of losing $1 million.

[18] *Tennessee CMHCs Forming Novel Alliance with Managed Care Firm*, 18 Mental Health Report 121, 122 (1994) [quoting Jason Weisser, Vice President for Development, Foundation Health Corp.].

[19] This is especially problematic for low-income people who are highly vulnerable to the institutional barriers to accessing services which have been erected by managed care. Melden, *Managed Care: How to Challenge Inadequate Access for Medicaid Beneficiaries*, Clearinghouse Review 228, 229 (July 1991) [referring to Ware, et al., *Comparison of Health Outcomes at a Health Maintenance Organization with Those of Fee-for-Service Care*, Lancet 1017 (May 3, 1986).

[20] The Commonwealth would actually have to dedicate less resources to public managed care than to private management as certain items, like profit, need not be included in the funds allocated to the program.

Appeals of District Court "Mental Health" Orders

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his/her brief within 20 days of receipt of appellant's brief. Appellant may file six copies and serve one copy of a reply brief within 14 days of receipt of appellee's brief. Rule 19(a).

The Appellate Division may order a prehearing conference in order to simplify or limit, by means of agreements or admissions, the issues. Rule 21. At oral argument, each party will be allowed 15 minutes. Rule 22(b). Appellant will argue first and must include "a fair statement of the case." He/she may request the opportunity to reply in writing to "new matter" in appellee's argument. Rule 22(c). Decisions are to be rendered promptly with further appeal to the Appeals Court.

Amicus briefs may be filed by leave of the Appellate Division. Counsel assigned through the Committee for Public Counsel Services (CPCS) always should notify CPCS of the taking of an appeal, as early in the process as possible, in order to obtain assistance, if desired, and to permit CPCS the opportunity to seek leave to file an *amicus* brief, if appropriate. Counsel also may want to contact advocacy agencies such as the Mental Health Legal Advisors Committee and the Protection and Advocacy Project for the same reasons.

ENDNOTES

[1] Citations herein to the new Appellate Division Rules are in abbreviated form—for example, what would properly be cited as Dist./Mun.Cts.R.A.D.A.1 will appear as

MANAGED CARE INITIATIVE EXPANDS; IMPACT CONTINUES TO BE FELT

Susan Fendell
Attorney, Mental Health Legal Advisors Committee

In the 1990s, the health care delivery system is changing dramatically, as health maintenance organizations, preferred provider networks and other selective arrangements assume greater importance in both the private and public health insurance markets. As the trend continues, hospitals, physicians and other medical providers are increasingly concerned about their inclusion in these select managed care networks. With health reform on the horizon, inclusion may well become a matter of survival.

--Managed Care Provider Networks, Getting In & Staying In, March 1994 conference brochure

Are you fully up-to-date on the latest managed care marketing strategies? Are you looking for revolutionary tactics to win sales contracts with managed care organizations?

--Selling and Marketing to Managed Care, November 1994 conference brochure

Automate treatment planning with a client-based, outcome-driven behavioral healthcare system....Eligibility information is more than demographics, it could include risk factors and outcomes....As behavioral health providers enter into private and public sector managed care networks, closely controlling service utilization and cost assumes great importance.

--Information Technology for Behavioral Health Management, January 1995 conference brochure

Driven by market forces and impending health care legislation, capitation is quickly emerging as the leading form of provider reimbursement. Is your organization ready to deal with the increasing pressure of cost containment in managed care? Are you ready to respond to the inevitable transition from fee-for-service to capitation reimbursement, which is already occurring at breakneck speed.

--Health Care Capitation and Risk Sharing, January 1995 conference brochure

Whether you are a state agency applying for federal waivers or a Managed Behavioral Healthcare payer or provider assessing and demonstrating your ability to hold a managed care contract, you cannot afford to miss this event!...Don't Miss our Feature Presentations from HCFA and the National Association of State Mental Health Program Directors!

--Medicaid Behavioral Health Capitation, April 1995 conference brochure

Popular wisdom these days is that managed care is the wave of the future and a done deal. Its popularity among Weld Administration officials is certainly clear. Managed care is integral to Governor Weld's welfare reform and Medicaid waiver request pending before the Health Care Finance Administration. The request for proposal for the Medicaid mental health and substance abuse managed care program is due out in July and new bids are likely to be due in September. Expected bidders include the current contractor, Mental Health Management of America (MHMA)[1], Options Mental Health, Medco Behavioral Care Systems, Value Behavioral Health, Inc., CMG, and Green Spring Health Services, Inc.,[2] all national players in the health management field. The award is scheduled to be made in November and the new contract will begin in January 1996.

This article examines the current status of the Medicaid mental health managed care program, as well as its impact on utilization of mental health services in Massachusetts.

Waiver

To continue its managed care programs, the Commonwealth must gain a waiver from the federal Health Care Financing Administration (HCFA) of Medicaid's freedom of choice provisions. At the time of publication, the Commonwealth's application for a managed care waiver was still pending. In December 1994, HCFA submitted follow-up questions to the Commonwealth's application, pinpointing how the 40% decrease in hospitals serving recipients under managed care affects access, how the proposal to allow up to 60 minutes in travel time for inpatient services compared to pre-waiver travel time, how medical record reviews will be conducted, and cost effectiveness.

Interface with the Department of Mental Health

For FY96, the Department of Mental Health (DMH), in its continuing efforts to privatize mental health care in the Commonwealth and implement "public managed care," plans to turn over management of acute hospitalization to the private management company which contracts with the Division of Medical Assistance (DMA).[3] While representatives of DMA have stated that the sole purpose of this union is to increase the buying power of both DMH and DMA,[4] it appears that the impact of this agreement is to turn over DMH's control of clinical decisions to a private corporation.

DMH will participate in the development of access, utilization, and quality management standards to be included within purchasing specifications and used internally by the managed care organization (MCO).[5] However, DMH will cede day-to-day decisions about acute care for individual clients to the MCO. In addition, under a preliminary agreement between DMH and DMA, DMA must review and approve DMH complaint investigation procedures at DMH licensed mental health facilities.[6] DMA also has the authority to approve DMH plans for licensing and review of both acute and continuing care providers, whether or not currently licensed by DMH.[7] Furthermore, the agreement permits DMH to delegate its licensing responsibility to

organizations and other state agencies. DMH currently has sole authority to determine the licensing provisions of facilities under its jurisdiction.

Complaints about clinical decisions will first be directed to a DMH area medical director and an MCO representative. If not resolved at that level, they will be handled by DMA and DMH central office staff. If still not resolved, the DMH Deputy Commissioner for Clinical and Professional Services will assume responsibility for resolution.[8]

Discharge Planning

The lack of discharge planning for children and adolescents leaving hospitals was highlighted in a September 1994 report showing that only 57% of hospitals and 42% of residential treatment facilities provided any discharge planning.[9] If any notation concerning the scheduling of aftercare, medication plans, guidance to the parents on how to deal with the child, or work with the family appeared in the discharge summary then discharge planning was considered to be accomplished. Given the low level of activity required to indicate that discharge planning was accomplished, the low percentage of facilities performing any discharge planning signals a major problem. MHMA acknowledged the problem, but attributed it in part to a shortage of staff in facilities; it gave these providers what it characterized as a modest rate increase in July 1994.[10]

Case management

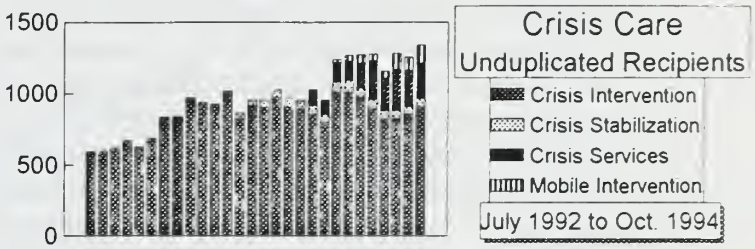
As of November 1994, the intensive clinical management (ICM) program was actively working with 236 adults and 70 children. Of all recipients in the program, almost two-thirds were referred due to the high cost of providing services or number of admissions;[11] the rest were referred due to clinical risk or pregnancy. Of the adults, 26% were substance abusers, 31% had been dually diagnosed, and 43% had a mental disorder as their primary diagnosis.[12] ICM clinicians do not replace DMH case managers or provide care; they coordinate care and track service delivery and outcomes.

One exciting aspect of the ICM program is the introduction of community support services for adults. These services are provided by persons with Bachelor level degrees and include such assistance as teaching daily living skills and transportation to appointments, as well as more traditional efforts such as medication management.[13] Since ICM for adults only began in August 1994 and support services were not operative until October 1994, no data is available to determine how extensively community support will be utilized.

ICM clinicians may also work with support teams for children and adolescents. Child and adolescent support services are actually rendered by family stabilization teams, which MHMA envisions will focus on child, as opposed to parental, support in this capacity. Like adult community support services, child and adolescent services will include such non-traditional Medicaid services as transportation. Both ICM and support teams for minors began in July 1994, so that insufficient data is available to gauge usage.

Family stabilization services

Family stabilization services, which were hailed by MHMA and family groups, do not appear to be receiving widespread use. There has been a moderate increase in the number of users since the first full month after their introduction in July 1993.[14] Expenditures per recipient are erratic but appear to be declining.



Crisis services

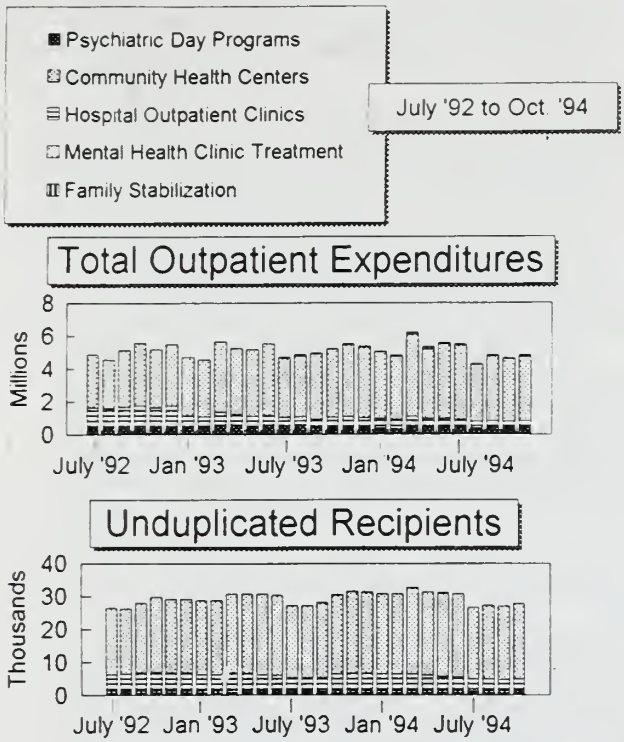
Continuing a trend previously reported in the *Advisor*,[15] both expenditures for and the number of recipients using crisis care[16] have increased substantially between October 1992 and October 1994 -- by 167% and 99% respectively.[17] Use of crisis care, however, does not appear to have resulted in any significant reduction in inpatient hospitalization. Total expenditures for hospitalization increased slightly from $3.4 to $3.7 million between October 1992 and October 1994.[18] Likewise, the number of unduplicated recipients who were hospitalized increased 13%.[19]

Recipients and family members complain that consumers are now being forced to jump through extra hoops to gain access to hospital care. MHMA stated that it would be investigating whether crisis expenditures are merely paying for duplicative evaluations of recipients (i.e., once by the crisis provider and again by the hospital).

Inpatient and Outpatient Trends

As noted above, total inpatient hospitalization expenditures and the number of unduplicated recipients using hospital services have remained relatively stable during MHMA's tenure.[20] According to MHMA, the average hospital stay has increased slightly for children and adolescents, from 14.1 days in 1993 to 14.7 days in 1994, and decreased for adults, from 10.1 to 9.5 days.[21] In the second half of 1992, the average length of stay for all recipients was 11.9 days.[22] By the last five months of 1994, the average length of stay was 9.9 for adults and 13.9 for children and adolescents.[23]

Some associate recidivism with length of stay. Between July 1992 and September 1994, the 30-day recidivism rate increased for adults (from 14% to 16%, with a peak of 19% in the third quarter of 1993) and stayed the same for both children and adolescents (6% for the former and 11% for the latter).[24] Others cite the lack of follow-up services as a contributing factor to recidivism.[25]



Despite initial promises by DMA and MHMA to increase outpatient care, particularly in light of their drive to reduce utilization of inpatient services, expenditures for outpatient therapy have not increased. Indeed, total expenditures for and the number of recipients using outpatient care have remained rather flat since the inception of MHMA's management.[26] (See charts.)

Some services have seen a decrease in expenditures per recipient. The per recipient expenditure for psychiatric day programs, for example, decreased by 20% between July 1992 and October 1994.[27] A DMA spokesperson asserted that some psychiatric day programs did not provide sufficient medical care, and MHMA had stated early on its belief that DMH clubhouses were a more appropriate setting for this type of longer-term care.[28]

The per recipient expenditure for outpatient care in clinics associated with hospitals also declined during the same period (54%). Again, MHMA and DMA have made no secret of the fact that they planned to limit the use of services in these settings, and, indeed, since the inception of the managed care program, both total expenditures for and number of recipients using hospital outpatient clinics have declined dramatically.[29]

MHMA stated in January that among its top priorities was better management of its outpatient network. DMA will be comparing MHMA utilization of outpatient services to that of other health maintenance organizations.[30] MHMA hopes that greater control of outpatient services, combined with the use of case management primarily for particularly high users of services, will result in a 2% savings in expenditures.

MHMA plans to allow outpatient providers who have operated within its treatment protocols[31] to provide service without prior authorization through July 1, 1995. MHMA assumed that most mental health diagnoses would be treated within six months, with expenditures of $1500 for persons entering care when in an acute stage and of $780 when entering care in a maintenance phase.[32] Statewide, MHMA outpatient providers have delivered services costing less than $780 to approximately 69% of recipients considered disabled and to 71% of other recipients. About 13% of disabled and 12% of other recipients were given outpatient services valued at more than $1500.[33]

MHMA will then review case samples from providers who, because of their treatment histories, were permitted to forego preauthorization, as well as "outliers" who were not.[34] MHMA will consider dropping some outpatient providers based on this case review and, in that event, will transfer patients to other providers in the same geographic area.[35]

Medication

Use of medication services, in contrast to the outpatient services just described, has increased markedly. Between July 1992 and October 1994, the number of recipients using mental health clinic medication increased by 38% and total expenditures increased by 81%. During that same period, the number of recipients enrolled in the program increased by 5%.[36]

MHMA's preference for medication and aversion to therapy is highlighted by its plans to increase rates for medication services and to change its rate structure in order to make group, rather than individual, therapy more attractive.[37] Medication rates for clinics were raised in April 1995 from $24.27 to $37.50 for each 15-minute unit.[38] Group rates will be raised from $7 to $9 for one-half hour of group therapy. The maximum number of persons permitted in a group is eight, which still makes the effective hourly rate of $144 for group therapy more attractive to providers than the rate of $65 per hour for individual therapy.[39]

In addition, when outpatient protocols were amended in May 1994, the protocol for medication was increased by six hours. On the other hand, maintenance for all diagnoses, which had previously been permitted on an indefinite basis, was limited to 26 hours in 52 weeks.[40] Two group therapy sessions of one and a half hours each may be substituted for one hour of individual therapy. Medication visits do not count toward the number of hours allowed under the protocol for therapeutic services.[41]

Summary

Cost containment continues to be the driving force behind managed care, including Massachusetts' experiment with Medicaid mental health and substance abuse services. Unfortunately, more than two years after the implementation of the program, one of the most telling indicators of quality of care -- recipient satisfaction -- has just begun to

continued on page 15

that most patients are already taking medication. One study revealed, for example, that Massachusetts courts granted 98% of the petitions for *Rogers* orders. *Id.* at 143, n.144.

[12] *Id.* at 56.

[13] While the term "asylum" enjoys a historical connotation as a place where an ill person could gain sanctuary or refuge, it also has evolved to denote an institution for the care, or sometimes warehousing, of the mentally ill. It is in this latter sense that the term is used here.

[14] David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (rev. 2d ed. 1990) at xxx.

[15] *Id.* For further discussion of the ascent of the asylum in Jacksonian society, see David Mechanic, *Judicial Action and Social Change*, *in* The Right to Treatment for Mental Patients 48 (Stuart Golann and William J. Fremouw eds., 1976).

[16] While the present "continuing care" population in Massachusetts of 995 represents a decrease in the number of long-term inpatients, the Commissioner of the Massachusetts Department of Mental Health (DMH) recently assured the legislature that a certain number of such beds will always be maintained. Testimony of Eileen Elias, DMH Commissioner, Executive Session of the Joint Committee on Human Services and Elder Affairs of Massachusetts, March 7, 1995.

[17] *See, e.g.*, John Q. LaFond & Mary L. Durham, Back to the Asylum: The Future of Mental Health Law and Policy in the United States (1992) at 114-115.

[18] *See, e.g.*, DMH Policy #94-4 Mandatory Forensic Reviews, implemented May 9, 1994, which requires forensic reviews for patients with certain identified criminal charges prior to the granting of privileges and discharge; the DMH Criminal Offender Record Information (CORI) pilot project, scheduled for implementation in March 1995, which allows DMH access to CORI of persons confined in public mental health facilities for use in risk assessment prior to the granting of privileges and discharge.

[19] For an account of this phenomenon, see Joe Sharkey, Bedlam (1994).

[20] For a consideration of this problem, see Louise Armstrong, And They Call It Help (1993).

[21] *See, e.g.*, Dateline NBC, Jan. 11, 1995, a television magazine in which a reporter questioned why an alleged assailant had been allowed to leave a New York City psychiatric facility.

[22] Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961) at 386.

[23] *Id.* at 369.

[24] Janet and Paul Gotkin, Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry (Harper Perennial 1992) (1975) at *xvi*.

[25] *Id.*

[26] Jeffrey L. Geller & Maxine Harris, Women of the Asylum: Voices from Behind the Walls 1840-1845 (1994) at 327 (emphasis added).

[27] Professional psychiatry is not the only source of the perception of a gap between psychiatric history and present day reality. Even the important personal testimonials of psychiatric survivors may reinforce this belief. For example, Susanna Kaysen's widely-read work, Girl, Interrupted, contributes to this problem by describing, in 1993, events which happened in 1967. Susanna Kaysen, Girl Interrupted (1993). Kaysen's book and other similar accounts have another unintended and unfortunate effect. Having gained distinction by penning personal accounts of institutionalization, these writers are accepted by the public and are distinguished from those less promising and less talented patients deemed needy of hospitalization. The publication of accounts of mental illness by already acclaimed persons such as William Styron and Kate Millet may reinforce this distinction.

[28] Alexander Vuckovic & Lisa Berger, Under Observation: Life Inside a Psychiatric Hospital (1994).

[29] Rothman, *supra* note 14 at *xliv*.

Managed Care *continued from 10*

be measured.[42] Therefore, concerns about access and quality remain.[43]

Before proceeding on the privately-managed care course, state and federal governments should examine closely whether the burden of continuing care is increased by the lack of acute and outpatient services[44] and whether rising private administrative costs result in a net loss of money for government. The government should further examine whether private management of mental health care results in a net loss of quality care for recipients and in a net loss of public good due to the loss of mental health systems motivated by humanitarian concern rather than profit. If the Commonwealth plans to proceed on its privately-managed care course, it should carefully craft its request for proposal, so that it limits administrative costs,[45] gives more than lip service to quality control, prohibits subcapitation,[46] ensures adequate discharge planning and outpatient care, and gives consumers more information as to who is making their care decisions.[47]

ENDNOTES

[1] It is also known as First Mental Health, Inc., a Tennessee subsidiary of First Health Services Corporation, which in turn is a subsidiary of First Financial Management Corporation.

[2] Green Spring is a Maryland-based company owned by a consortium of Blue Cross/Blue Shield plans. The former director of Massachusetts' Medicaid Mental Health/Substance Abuse Program joined Green Spring this year. The company was recently selected to be a manager of mental health care benefits for Medicaid recipients in Tennessee. The contract is worth about $200 million in annual revenues. *Green Spring Wins Tennessee Contract*, 19 Mental Health Report 47 (1995).

[3] DMH will remain responsible for long-term and continuing care. Department of Mental Health & Division of Medical Assistance, Managed Mental Health Services, Roles and Responsibilities: A Framework for Collaboration 3-4 (1995)(available from the Department of Mental Health).

[4] DMH already contracts with private hospitals for acute care that formerly was provided in state hospitals. DMH beds in private facilities hence are called replacement beds.

[5] DMH & DMA, *supra* note 3. DMA is responsible for procuring and supervising the managed care company. *Id.* at 4-5. The agreement also states that DMH and DMA shall jointly approve the selection of the company, *id.* at 6, in contradiction with the former provision and current practice.

[6] *Id.* at 4.

[7] *Id.*

[8] *Id.* at 6.

[9] MHMA, Measuring the Process of Acute Care for Children & Adolescents, Key Report Findings (Sept. 24, 1994).

[10] The issue of the lack of adult discharge planning will be addressed by MHMA staff looking at readmission rates. The exact extent of the problem is unknown. However, anecdotal evidence, such as a battered woman who, in lieu of any assistance with aftercare planning, was handed a list of shelters as she was discharged from an MHMA hospital, indicates the need for work on this front. MHMA has stated informally that about 100 people were discharged to the streets in 1993.

[11] High cost means greater than $40,000 spent on services in twelve months. More than five acute admissions in twelve months triggers referral to case management. Eunice Hartman, MHMA, Intensive Clinical Management Program (March 2, 1994).

[12] MHMA, Intensive Clinical Management Program Implementation Update (Dec. 2, 1994); comments by MHMA at Dec. 2, 1994 Mental Health/Substance Abuse Program Advisory Group meeting.

[13] Hartman, *supra* note 11. In Region I (Boston), Metro Boston Community Services (Brighton Allston) was the only provider of these services as of December 1994. Metrowest Mental Health Association and Somerville Mental Health Association were chosen for Region V (Greater Boston). MHMA, *supra* note 12.

[14] Utilization ranged from 35 recipients in August 1993, to a peak of 97 families in April 1994, and back down to 34 recipients in July 1994. The October 1994 figure of 58 recipients is generally representative of usage. MHMA Expenditure Report (Jan. 29, 1995).

[15] Fendell, *Managed Care Update*, 41 Advisor 9-10 (1994).

[16] Crisis services include:

Crisis intervention: prescreen and assess persons at risk of hospitalization, stabilize and divert unnecessary hospital admissions, provide immediate and short-term mental health services, including medication, and consultation to individuals and MHMA-funded programs

Mobile crisis intervention: same as crisis intervention except the Boston Emergency Services Team which renders this service has a different rate structure

Crisis services: crisis intervention by a clinic or individual practitioner for a recipient under their treatment; clinics and practitioners are supposed to refer any recipients appearing to need hospitalization to crisis intervention teams

Crisis stabilization: beds for recipients that meet the medical necessity criteria for inpatient admission but do not need continuous medical/nursing care or a locked setting; evaluation, observation, and treatment planning

[17] MHMA, *supra* note 14. Even just looking at intervention services, total expenditures have increased 92% and recipients using those services by 54%. *Id.*

[18] MHMA reduced total expenditures for hospitalization significantly when it negotiated lower rates for MHMA network hospitals. Although MHMA performed utilization review as early as July 1992, MHMA began its network management of hospitals in October 1992. Fendell, *Managed Care in the Medicaid Mental Health System: Verdict Out, Concerns Abound*, 38 ADVISOR 10 (1993).

[19] The increase in the number of recipients hospitalized partially reflects an increase in enrollees in the mental health managed care program.

[20] MHMA, *supra* note 14.

[21] MHMA, Average Length of Stay for 24-Hours Services, Calendar Year 1993 and 1994 (undated).

[22] MHMA, Detail Variance Report, MH/SA Acute I/P ALOS (Discharge)(July 8, 1993).

[23] MHMA, Utilization Analysis Summary, MH Acute I/P Authorized (Dec. 14, 1994). Parent group complaints about the high recidivism rate for children and the lack of access to care may have contributed to MHMA's tendency to authorize longer lengths of stay for children than adults.

[24] MHMA, Massachusetts MH/SAP Inpatient Readmission Rates (based on claims data as of 1/13/95). Information as to 60 and 90-day recidivism rates were unavailable. The 30-day recidivism rate for DMH facilities was 3.6% for children/adolescents and 12% for adults in FY93 and 4.2% for children/adolescents and 10.8% for adults in FY94. The recidivism rate for DMH replacement units was much higher, 14.2% in FY93 and 17.4% in FY94. John Widdison, Public Affairs, DMH, Memorandum (Nov. 15, 1994).

[25] Both MHMA and DMH lack adequate follow-up services. There is an approximately 20-day waiting period for MHMA outpatient services at mental health clinics in the Boston area. DMH lacks sufficient supported residential settings.

[26] MHMA, *supra* note 14.

[27] Total expenditures for psychiatric day programs decreased by 18%. The number of recipients using the programs has been erratic, dipping precipitously in fall/winter 1993 and ending October 1994 at a 2% increase over July 1992. *Id.*

[28] MHMA also cites the September 1993 introduction of partial hospitalization as a step-down service as one reason that the use of psychiatric day programs declined. Partial hospitalization, which is also used as a diversionary service, does not fully account for the drop in psychiatric day program expenditures between July 1992 and October 1994, as the amount of expenditures for partial hospitalization in October 1994 is only about 40% of the drop in expenditures for psychiatric day programs. Furthermore, the number of recipients using partial hospitalization when the service was introduced accounts for only a third of the drop in recipients using psychiatric day programs up until partial hospitalization's introduction. *Id.*

[29] Total expenditures for hospital outpatient clinics decreased 68%; the number of recipients using these services decreased 32%. *Id.*

[30] Given the far from shining reviews which consumers bestow upon health maintenance organizations like Blue Cross/Blue Shield, which was sued by its insureds for failure to provide access to mental health services, Boston Globe, June 29, 1994, at 28, col. 1; *see also*, Boston Globe, March 28, 1994, at 21, col. 2, and Harvard Community Health Plan, about which complaints have been levied that it prefers immediate medication to therapeutic examination of underlying issues, this comparison of MHMA outpatient utilization to other managed care companies may not yield much useful information as to the quality of care.

[31] *See* Fendell, *Mental Health Managed Care: Service Expenditures Down - MHMA Profits Up*, 39 ADVISOR 31 (1993).

[32] MHMA, MHMA MH/SAP Bulletin 1995-1, Outpatient Information (1995).

[33] *Id.* The six-month segments studied were from September 1993 through June 1994. The Boston region consistently utilized less outpatient care, while Southeastern Massachusetts consistently utilized more.

[34] *Id.*

[35] MHMA already has restricted the number of hospitals providing coverage to recipients from 65 to 46.

[36] MHMA, MH/SAP Enrollment July, 1992 to December, 1993 (undated); MHMA, MH/SA Program 1994 (Dec. 14, 1994). The proportion of recipients categorized as disabled increased from 15.7% to 16.7% during that time period.

[37] Mental Health Corporations of Massachusetts, Inc., an industry organization that represents the larger mental health clinics, lobbied MHMA for these changes. Indeed, it stated in a June 1994 letter to MHMA that group therapy rates should be increased so that providers would "view group as the model of choice for all individuals for whom individual or family therapy is not unquestionably and absolutely clinically necessitated." It based its push for higher medication rates on the limited profitability of medication rates as clinics feel compelled to pay psychiatrists $110,000 to $144,000 per year in a market where there is a shortage of psychiatrists.

[38] In May 1995, MHMA plans to lower rates for medication visits by individual practitioners from $60 to $37.50 on the theory that similar services should be compensated at the same rate regardless of who provides them.

[39] Prior to this rate change, individual case workers complained that the pressure towards group therapy discriminated against those in need of individual therapy.

[40] MHMA, *supra* note 32. Other changes made were an increase of hours for anxiety disorders in the acute phase (4 hours) and separate guidelines for children.

[41] *Id.*

[42] The full results of a consumer satisfaction survey for consumers of outpatient services are not yet published. MHMA conducted the 2,560-recipient survey by mail, stating that in-person surveys are too expensive and that only 20% of recipients had listed telephone numbers. Unfortunately, the Government Accounting Office has found mail surveys to be less conclusive and more positive than in-person interviews. GAO, No. GAO/PEMD-94-19, LONG-TERM CARE: STATUS OF QUALITY ASSURANCE AND MEASUREMENT IN HOME AND COMMUNITY-BASED SERVICES 22 (1994).

A total of 738 questionnaires were returned for a 29% response rate; 24% were returned as undeliverable. Most of the respondents were female (77%) and white (70%). The responses were generally favorable, with some dissatisfaction expressed concerning how busy the staff seemed, medication issues (choice and informed consent), the amount of information given about other resources in the community and consumer rights, and the ability to access the clinic as frequently as needed and still be covered by insurance. MHMA found that treatment with respect was the biggest predictor of consumer satisfaction.

[43] "In today's health care environment, health care fraud does not necessarily mean overutilization or fraudulent billing. It may entail underutilization...." *Psychologists Meet with DOJ Staff To Discuss Managed Care Abuses*, 19 MENTAL HEALTH REPORT 40 (1995).

[44] One DMH area director complained that due to finance-driven decisions by managed care companies to shorten hospital stays, and the resultant higher recidivism rates, consumers appear chronically mentally ill, and hence more appropriate for long-term DMH care, although they are not. Several direct care workers in residential facilities stated that residents were being discharged from facilities prior to stabilization of their medications or before the residents themselves felt ready to leave. This has created difficulties for other residents and facility staff, which is exacerbated by the limited amount of funds allocated to procuring and keeping staff at publicly-funded residential facilities.

[45] Limits on the gains from cutting service expenditures are absolutely necessary to remove any incentive to slash and burn services in favor of higher profits. Limits on the amount of administrative expenses borne by the state are also necessary, given that many of the expenses either go to parent company profits or to capital investments, such as information systems, the benefits of which accrue to the private company whether or not that particular company continues to contract with the state.

[46] Sub-capitation creates an even more severe conflict of interest between the caregiver and the patient than exists under the present managed care system. See Fendell, *Mental Health Managed Care: MHMA Report Card Mixed - Conflict Between Profits and Consumers*, 40 ADVISOR 5, 8 (1994).

[47] A significant problem with the "seamless system of care" that the Weld Administration is attempting to create is that consumers do not know what agency or corporation is making care decisions for them. *See* Fendell, *supra* note 31, at 14.

MHLAC TELEPHONE INTAKE HOURS

Mondays, 1 p.m. to 3 p.m.

Wednesdays, 1 p.m. 3 p.m.

At these hours, advocates are available by telephone only to provide advice, assistance, information and referrals.

MHLAC is not able to offer walk-in assistance.

MENTAL HEALTH MANAGED CARE: EXPANSION TO DMH ACUTE CARE AND MEDICAID UPDATE

Susan Fendell
Attorney, Mental Health Legal Advisors Committee

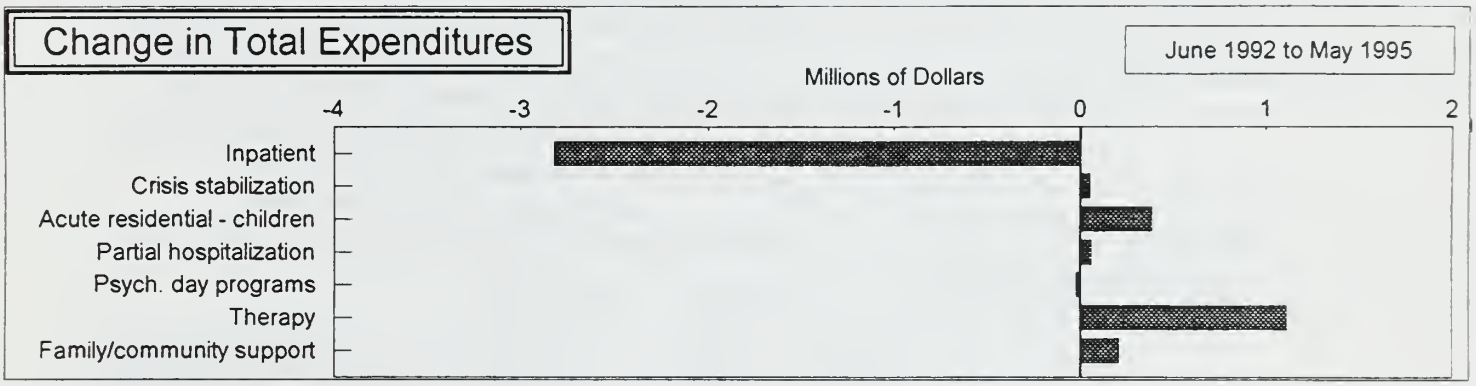
DMA/DMH RFP

A Request for Proposal (RFP) released September 22, 1995[1] represents a significant expansion of managed care by the Commonwealth.[2] Department of Mental Health (DMH) inpatient acute care will be placed under the management of a private managed care company as early as May 1, 1996 and no later than July 1, 1996. Under the new arrangement, the company hired by the Division of Medical Assistance (DMA) will purchase and manage emergency,[3] acute inpatient, and diversionary[4] services for DMH.

Network Management

The RFP allows for subcapitation in the third year of the contract,[5] despite criticism by advocates that subscapitation would exacerbate an already existent financial conflict of interest between the caregiver and the patient.[6]

The RFP does have positive elements, however. It retains a minimal level of freedom of choice for recipients by requiring the company to permit changes of providers within the company's provider network.[7] It also places importance on discharge planning, a problem area in the past, by attaching potential sanctions to abysmal performance in this area.[8] Sanctions are also applicable to untimely inpatient admissions, inappropriate referrals to DMH continuing care services, delayed prior approval decisions and payments to providers, and late submission of various reports to DMA.[9]



The RFP clearly answered the concerns of providers more than of consumers. For example, in contrast to the relatively stringent standards for the prior approval process, the sanction for a high recidivism rate is applicable only if more than 5% of discharges from hospitals, freestanding detoxification facilities, and acute residential treatment facilities result in readmission to one of these facilities within seven days of discharge.[10] Although 5% is lower than the adult 30-day recidivism rate of 16% within MHMA's system,[11] the standard measure of recidivism is between 30 and 90 days.

Human Rights

Some mental health professionals and consumer advocates have expressed great concern about the impact of this RFP on DMH consumers.[12] A major issue is whether human rights within private facilities will have fewer safeguards than in DMH-operated facilities. This is a facet of the general concern that DMH is giving up its supervisory role to DMA and the management company.

The RFP provides minimal assurance that rights will be observed by facilities contracting with the management company. For example, the RFP allows DMA to annul DMH human rights requirements in existing contracts for replacement units.[13] Furthermore, rather than requiring hospitals to abide by human rights regulations and policies applicable to state-operated facilities, the RFP allows hospitals to craft their own human rights protocols, albeit they must be "consistent with" DMH human rights policy[14] and are subject to review and approval by DMH.[15]

Financial Incentives

A second critical issue is the financial incentive to the management company to cut costs. Consumer advocates contend that quality controls are difficult to develop and enforce, and that the financial incentives inherent in private managed care often lead to cutting services at the expense of quality. The RFP leaves the issue of financial incentives

with respect to Medicaid recipients unsettled by making risk sharing arrangements subject to negotiation.[16] The RFP does make it clear that "neither [DMA] nor the Contractor will bear full risk for service expenditures," but that DMA will not pay more than 95% of what it would have paid if it had rendered the services on a fee-for-service basis.[17]

The financial incentives with respect to DMH consumers encourage the managed care company to limit payments for covered services. The company is required to maximize use of the Uncompensated Care Pool for DMH consumers.[18] It may keep 20% of the savings on inpatient and diversionary services, up to $250,000 per year.[19] The management company may not keep any savings associated with emergency services, but it may receive an incentive payment of up to $200,000 if it identifies a certain proportion of persons using emergency services as Medicaid eligible.[20] Incentive payments are also provided for increased collections from other insurers such as Medicare.[21] The management company also may keep savings on administrative costs of up to 10% of those costs, which are based on the marginal cost to serve DMH consumers.[22]

The DMH incentive package attempts to put more of the responsibility for the costs of mental health services on federal and other non-state funded programs. Theoretically, it is appropriate to pay for services with the program specifically designed to meet that particular category of poverty. However,whether the money comes from Medicaid, Medicare or DMH, it is all public money.[23] The DMH system of incentives, which requires diversion of public monies to a private company to accomplish this shuffling of debt, speaks to the need for a single payor system. Under the single payor system, the government would administer a single health care program, thereby eliminating unnecessary payments to management and insurance companies and preserving funds for health care services themselves.

MEDICAID UPDATE

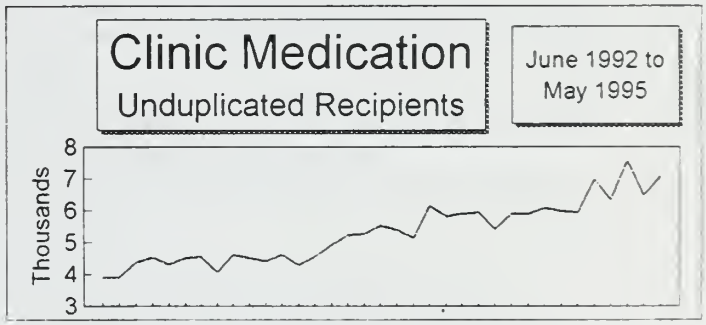
Medication

As previously reported, use of medication is on the upsurge, with total expenditures for mental health clinic medication increasing almost three-fold (295%) in the three-year period between June 1992 and May 1995.[24] The number of unduplicated recipients using this service increased by 82% during this same period, but the number of recipients who were disabled rose only 3%, from 16 to 19%, and total enrollees by 11%.[25] Expenditures per recipient were up by 117%.

The most surprising element in this medication heyday is that medication of non-disabled recipients climbed at a far faster rate than that of disabled recipients.

Mental Health Clinic Medication
Percentage Increases Between June 1992 and May 1995

	Non-disabled	Disabled
Total Expenditures	658%	166%
Unduplicated Recipients	234%	20%
Expenditures Per Recipient	127%	122%
Units of Service	415%	77%



Therapy

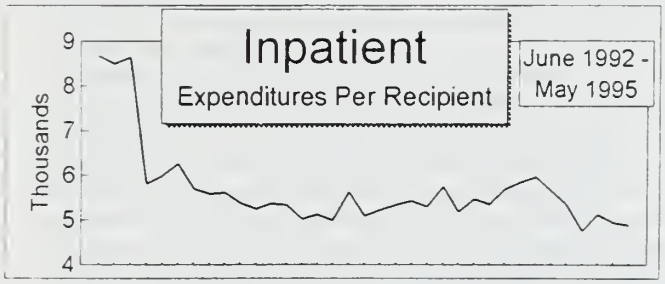
Another surprise is that the rush to medication did not coincide with a reduction in therapy for non-disabled recipients. Rather, while expenditures dropped dramatically for services rendered by hospital outpatient clinics, units of service and the number of non-disabled recipients using that service did not. Furthermore, although expenditures per recipient grew at a far slower rate than the number of persons using the services, expenditures for and the number of non-disabled persons receiving services from mental health clinics and community health centers grew.

Disabled recipients, on the other hand, experienced large cuts in mental health clinic and hospital outpatient therapy. Between June 1992 and May 1995, the number of disabled recipients seen by clinics dropped 13% and by hospital clinics by 15%. Expenditures per recipient fell 9% in clinics and units of treatment by 4%. Units of treatment rendered to disabled recipients by hospital clinics dropped by 25%.

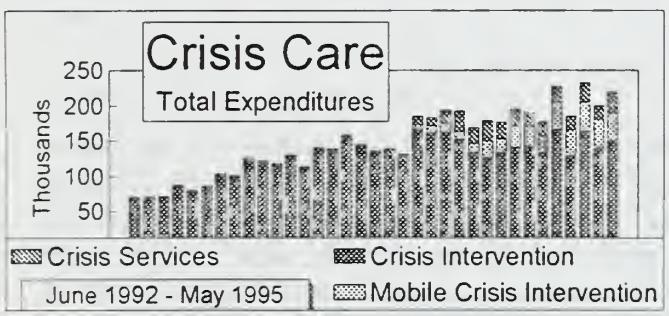
Overall, expenditures for outpatient services[26] have increased. This is partially due to an increase in the number of recipients using the services and partially due to the addition of new services, such as community support services, that are primarily used to divert recipients from hospitalization. However, even looking solely at therapy, total expenditures have increased by 25% and the number of recipients using these services has increased by 34%. In addition, the decrease in expenditures per recipient of 15% seems to be attributable to a reduction in rates paid to hospital clinics although it may also be attributable to a drive toward group as opposed to individual therapy.[27] Nevertheless, the increase in total expenditures for outpatient services is less than half of the reduction in expenditures on inpatient services.[28]

Inpatient

Expenditures - total and per recipient - for adult inpatient services continue to decline. Between June 1992 and May 1995, they fell by 41% and 44% respectively.[29] The same is true for children's hospital expenditures; both total and per recipient dropped by 53%. The use of crisis stabilization, an alternative to hospitalization that has been greeted warmly by consumers, is on the rise, but expenditures per recipient are erratic.



As reported earlier, the surge in crisis intervention services[30] has not stemmed the number of recipients hospitalized, as the number of unduplicated adult recipients increased by 5% and the number of children remained the same. The question as to whether crisis intervention services are truly performing a valuable role, or are merely duplicative to hospital intake and an unnecessary obstacle for recipients to overcome prior to hospitalization, remains unanswered.



At the same time that hospital services for children are being cut back, the use of acute residential treatment for children and adolescents is escalating. Between October 1992 and May 1995, total expenditures rose 774%, expenditures per recipient were up 67%, and the number of children and adolescents placed in these settings climbed by 423%.[31] On the other hand, spending for partial hospitalization for children is erratic, with the most recent monthly figure showing a decline of 39% since its inception in September 1993. This is primarily a result of a 46% decrease in the number of children using the service, which never reached 50 in any one month.[32]

ENDNOTES

[1] Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance, Request for Proposals for Mental Health/Substance Abuse Program (Sept. 22, 1995).

[2] During the summer, the Commonwealth of Massachusetts was granted a waiver of Medicaid regulations by the federal government, thereby permitting it to continue its use of managed care for Medicaid recipients. Full implementation of the waiver request requires enabling state legislation.

[3] DMH covered emergency services are emergency screening services, medication management services, crisis stabilization, observation/holding beds, specialing services (therapeutic services provided on a one-to-one basis to maintain an individual's safety), and crisis counseling.

[4] DMH covered diversionary services are crisis stabilization, observation/holding beds, partial hospitalization, and psychiatric day treatment.

[5] DMA requires preapproval of subcontracts that provide for capitated payments or other risk-sharing, RFP 40, and retains the right to review and approve all subcontracts with providers, RFP 24. For some reason, DMA requires only the non-capitated risk sharing arrangements to balance cost incentives with access and quality incentives. RFP 40.

[6] Payments on a capitated basis are calculated per recipient or block of services (e.g., per admission to hospital regardless of length of stay). Unlike payments based on services rendered (fee-for-service), the provider has an incentive to cut services in order to keep its costs below the capitated rate. See Fendell, *Mental Health Managed Care: MHMA Report Card Mixed - Conflict Between Profits and Consumers*, 40 ADVISOR 4, 8 (1994); Fendell, *Managed Care Initiative Expands; Impact Continues to Be Felt*, 42 ADVISOR 8, 15, 16 n.46 (1995).

[7] RFP Appendix B 20.

[8] RFP 31. DMA may impose a penalty of up to $100,000 if less than 85% of recipients have an outpatient visit within three days of discharge from an inpatient facility and up to $200,000 if the rate falls below 80%.

[9] RFP 32-35.

[10] RFP 31-32.

[11] Recidivism rate is for September 1994. MHMA, Massachusetts MH/SAP Inpatient Readmission Rates (based on claims data as of Jan. 13, 1995).

[12] A coalition of organizations such as AFSCME, the Alliance for the Mentally Ill, and the Consortium for Psychotherapy was formed in response to this expansion of managed care.

[13] Replacement Units are to be operated in accordance with the terms of the Replacement Unit Contracts, "until otherwise directed" by DMA. RFP 18.

[14] DMH Human Rights Policy # 95-4 (Feb. 23, 1995).

[15] RFP Appendix B 8. The DMH Service Standards are not only subject to negotiation, see *id.*, but also permit the hospital to develop its own patient rights policy. RFP App. K, Acute Inpatient Program Standards Section II.2.01.a.

[16] RFP 30-31.

[17] This includes incentive and bonus, as well as risk sharing payments. RFP 30; see also *id.* at 14.

[18] RFP 36.

[19] RFP 37. The management company is also liable for 20% of any amounts spent on inpatient and diversionary services above the budgeted amount for up to $350,000. RFP 37-38.

[20] RFP 38-39.

[21] RFP 39.

[22] RFP 37. All of the aforementioned arrangements are only for the first year; everything may be renegotiated thereafter. If DMA and the management company can not agree to new terms, the existing arrangement remains unchanged. RFP 39-40.

[23] The Uncompensated Care Pool consists of revenues from assessments on hospitals, but is nonetheless a limited and inadequate source of funds for persons whose medical bills exceed their resources.

[24] Unless otherwise noted, all statistics in this section are from Mental Health Management of America's Aug. 26, 1995 Expendi-

ture Report.

[25] RFP DMA Data Book, Penetration Rate by Category of Assistance.

[26] Outpatient services included in this calculation are psychiatric day programs, community health centers, hospital outpatient clinics, mental health clinic treatment, family stabilization, and child/adolescent stabilization services.

[27] Fendell, *Managed Care Initiative Expands; Impact Continues to Be Felt*, 42 ADVISOR 8, 10 (1995).

[28] Added expenditures on evaluation and consultative services, as well as alternatives to hospitalization like partial hospitalization, residential services, and crisis stabilization, still do not result in a figure equal to the amount by which expenditures on inpatient services were reduced.

[29] Length of stay dropped from 13.47 days in October 1992 to 10.25 days in March 1995. RFP DMA Data Book.

[30] Between June 1992 and May 1995, crisis intervention total expenditures increased by 114%, expenditures per recipient increased by 30%, and number of recipients using the service increased by 65%. Between January 1994, when crisis services were introduced, and May 1995, total expenditures, expenditures per recipient, and number of recipients using the services increased by 209%, 6%, and 192% respectively. Between March 1994, the inception date of mobile crisis intervention, and May 1995 total expenditures, expenditures per recipient, and number of recipients using these services increased by 619%, 7% and 573% respectively.

[31] Length of stay also appears to be increasing, reaching a high of 14.16 days in December 1994 as compared to a low of 7.95 days in October 1992. RFP DMA Data Book.

[32] Total expenditures for partial hospitalization for adults rose by 123%, due to a 130% increase in recipients using it. Expenditures per recipient decreased by 3%, while, for children, the figure increased by 15% during the same September 1993 to May 1995 period.

ROOM PLANS *continued from page 2*

mission on Accreditation of Healthcare Organizations (JCAHO), despite characterizing room plans as a "special treatment procedure requiring clinical justification," do not require informed consent for the use of behavior-management procedures for controlling maladaptive behaviors.[9]

Despite the clear legal and administrative requirements that room plans be used in a consensual manner only, even within DMH facilities patients currently are placed on room plans in the absence of fully informed consent. Additionally, patients have been placed on room plans with features to which they have not (and perhaps could not) explicitly agree, such as prohibitions on telephone calls and visitation during periods of confinement.

Further, the designation of an intervention as treatment does little to invoke other legal strictures. While requiring consent of the patient and/or guardian in order to protect patients from intrusive treatments, Massachusetts law does not specifically dictate what types of behavioral interventions are permissible in treating persons in its facilities.[10] Further, while other state agencies, such as the Department of Mental Retardation (DMR),[11] do have regulations concerning the use of behavior modification techniques, DMH has no such regulations.[12] Finally, while JCAHO provides certain standards for accredited psychiatric hospitals regarding behavior management procedures, with respect to non-aversive treatments the guidelines do little more than require that the hospitals themselves develop mechanisms to govern the use of such interventions.[13]

By contrast, designating room plans as a ward management intervention, as opposed to a form of treatment, suggests that implementation no longer requires patient consent. Ward management interventions have historically been justified as a necessary tool of facility staff in their efforts to maintain a safe and therapeutic environment and have not necessitated patient or guardian consent prior to implementation. For example, Massachusetts facilities currently rely on day hall restriction, the involuntary restriction of a patient to a common area of the ward, for purposes of behavioral management.

Current ward management techniques substantially restrict individual liberty, and one might dispute the notion that a category of such techniques should be available to hospital staff. The debate over the need for consent to room plans may be a red herring, avoiding the argument that these techniques, like seclusion, should not be justified by a desire to secure the ward or by patient consent, but only by the existence of a narrowly-defined emergency situation.[14]

The classification of room plans as either treatment or ward management is untenable in another respect. While positioning this intervention into one or the other camp may dictate its stated purposes, it does not define its ultimate effects on patients. By exploring the theoretical roots for room plans, in clinical literature about similar forms of interventions, we begin to understand that a room plan may simultaneously resemble treatment *and* ward management.

How does a room plan look like other forms of behavior management?

Seclusion

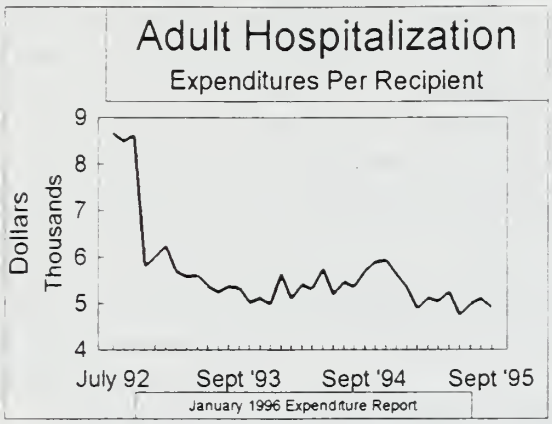
Room plans bear resemblance in certain respects to seclusion, a form of involuntary confinement of a person. During seclusion, a clinician is not required to obtain the informed consent of a patient ordinarily required prior to the administration of treatment,[15] but may confine or restrict a patient without the patient's permission.

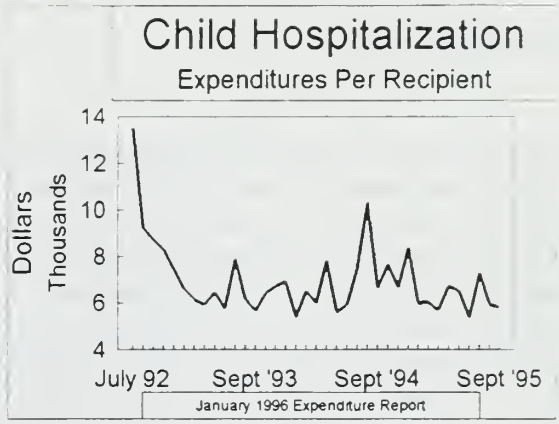
While precise definitions for seclusion may vary, Massachusetts law defines "confinement in a place of seclusion other than the placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit freedom of movement" as forms, among others, of "restraint," thereby subjecting these interventions to an extensive set of controls.[16] More specifically, the corresponding regulation describes what constitutes seclusion: "Except when a patient is placed in his or her room for the night, seclusion occurs whenever a patient is both confined and isolated."[17] Confinement occurs when the patient cannot leave or believes that he or she cannot leave.[18] Isolation occurs when a person is placed in a room so that he or she

Managed Care Trends

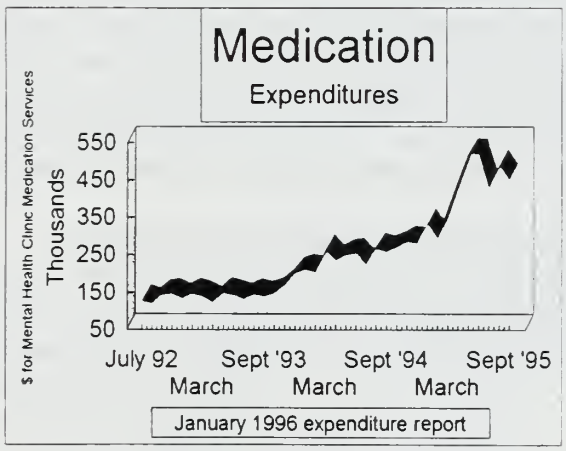
Susan Fendell
Attorney, Mental Health Legal Advisors Committee

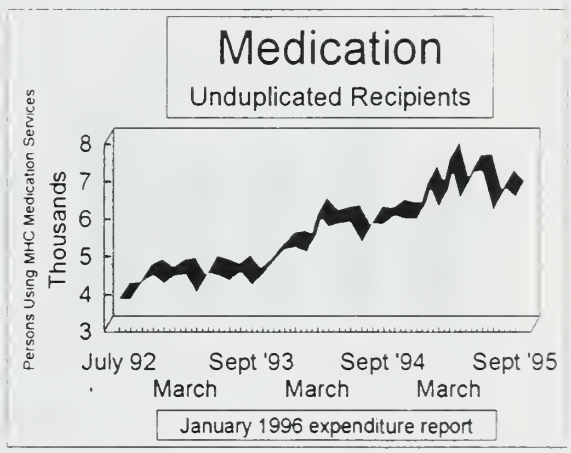
Inpatient expenditures per recipient remain at their lowered levels:



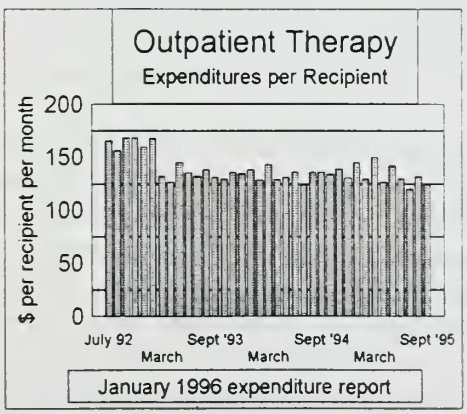


While both the expenditures for and number of persons referred to medication visits continue at dramatically increased levels:





Spending on outpatient therapy per recipient is lower than in 1992:



Fact Check

With almost 373,000 recipients enrolled in the Medicaid mental health managed care program, Mental Health Management of America provided the following amount of services in the month of September 1995:

Community Support	19 recipients
Family Support Services	82 recipients
Partial Hospitalization	17 recipients
Crisis Stabilization Beds	203 recipients
Flex Benefits	1 recipient

The "New" Face of Managed Care in Massachusetts:

Susan
Senior Attorney, Mental

"The Partnership" has come to Massachusetts. Two large national managed care corporations,[1] Value Behavioral Health, Inc. and FHC Options, have joined together to win Massachusetts' Medicaid managed care contract with a low-ball bid. Although Massachusetts has opted for the private management of mental health and substance abuse services since 1992, providers face the future with anxiety about authorization of services. At the same time, consumers fear that their caretakers will be unlikely to advocate for them as providers jockey for a place in the Partnership's network, which will rely heavily on increased risk sharing.

The contract for management of Medicaid behavioral health services and the Department of Mental Health's (DMH) acute care services was awarded following a lengthy process. In March 1995, the Division of Medical Assistance (DMA) issued a Request for Information, requesting input as to the form of the DMA/DMH contract. The Request for Proposal followed in September 1995. Five companies bid for the contract.

The evaluation process was effectively closed to the public. The advisory committee to DMA and DMH regarding the contract included no consumers and only one family member, who was not currently involved with any of the family groups active on this issue, such as the Alliance for the Mentally Ill or the Parent/Professional Advocacy League. There was some very limited consumer input when DMA released dribs and drabs of the RFP responses to M-Power.[2] Significantly, however, neither M-Power nor the official advisory committee was permitted to see the financial heart of the RFP responses: the proposed capitation rates.

The contract itself was signed at the last minute following what DMA and Partnership representatives described as intense negotiations.[3] The Partnership took over responsibility for Medicaid's mental health/substance abuse program on July 1, 1996.

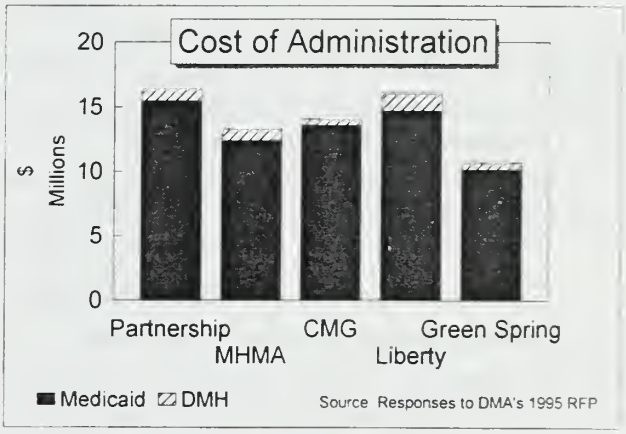
BID COMPARISON

DMA

The Partnership undercut the other bidders – CMG Health, Inc.,[4] First Mental Health, Inc. (better known as MHMA),[5] Green Spring Health Systems, Inc.,[6] and Liberty Healthcare Corporation & Intracorp[7] – with respect to proposed expenditures for Medicaid services. In contrast, the Partnership had higher administrative costs than other bidders.

In its DMA proposal, the Partnership suggested an earnings rate of 8% and total administrative costs of $15.4 million,[8] with a monthly capitation rate for service of $22.82 for AFDC recipients and $61.80 for disabled recipients for year one.[9] To achieve this minimal capitation rate, the Partnership planned, among other things, to significantly reduce the use of inpatient mental health services and the number of sessions per recipient for mental health clinic treatment.[10] It planned to increase the use of partial hospitalization, acute residential treatment, and crisis services.[11]

Liberty, on the other hand, suggested an earnings rate of 14% and total administrative costs of about $14.7 million, with a monthly capitation rate for service of $27.46 for AFDC recipients and $67.61 for disabled recipients.[12] Liberty envisioned a 5% decrease for disabled recipients and 10% decrease for other recipients in inpatient hospitalization with a concurrent "dramatic" increase in residential stabilization, a 20% increase in crisis services, a 10% increase in psychiatric day treatment, a 10% decrease in psychological testing, a 2% treatment in use of outpatient hospital clinics, and a 10% decrease in mental health clinic treatment.[13]



CMG proposed a capitation rate of $25.45 for AFDC recipients and $70.76 for disabled recipients,[14] based upon a 5% reduction of outpatient mental health services in year one, a 13% reduction in inpatient days for AFDC recipients based on a reduced length of stay from 10.4 to 9.0 days in year one, a 4% decline in inpatient hospital admissions for disabled persons as well as a reduction of the average length of stay from 12 to 11 days, reductions in residential expenditures for AFDC recipients coinciding with some increased use of child/adolescent support teams, a significant expansion of community support programs for disabled persons, and a 12% reduction in psychiatric day treatment utilization.[15] CMG's proposed administrative cost was $13.5 million.[16]

MHMA, considered by many providers to be more "benevolent" with respect to service authorization than other managed care organizations, proposed service capitation

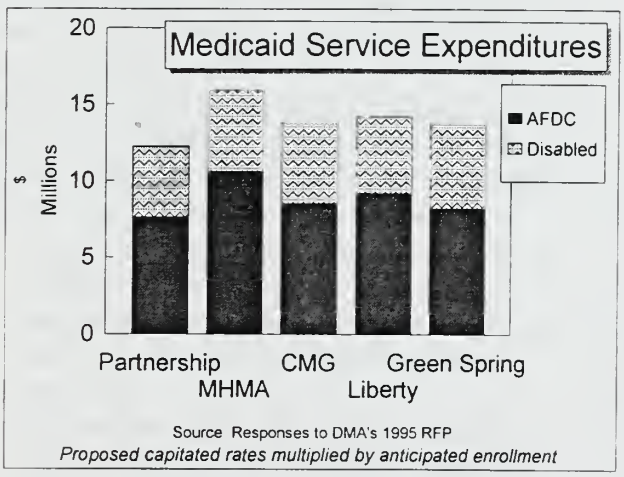
Medicaid's Partnership with DMA and DMH

Fendell
Health Legal Advisors Committee

rates higher than the other bidders: $31.71 for AFDC recipients and $71.35 for disabled recipients.[17] Its administrative costs were lower, almost $12.4 million, but its earnings rate was high, 15%.[18]

Green Spring proposed the lowest administrative costs: $10.1 million with an earnings rate of 6%,[19] and the greatest difference between the capitation rates for AFDC and disabled recipients: $24.57 and $74.17, respectively.[20] Its low administrative costs were matched by the minimal number of full-time employees whom it proposed to hire: only 90,[21] compared to the Partnership's high of 177.[22]

The proposed allocation of savings/excess spending to DMA and the managed care organization differed between bidders. The Partnership proposed to keep all the first 6% of savings (and be responsible for all the first 6% of excess spending); the remainder would be split, with 67% to the Partnership and 33% to DMA.[23] Liberty, assuming that the service capitation rates were below what DMA would pay on a fee for service basis, wanted to keep all savings achieved and bear 20% of expenditures above those capitation rates.[24] CMG capped its gains and losses on clinical expenditures at $4 million, sharing both with DMA on a 50/50 basis until the cap was reached.[25] Green Spring was the only bidder to suggest that a specific portion of savings be allocated to the funding of additional services for recipients.[26] Its formula allocated savings 25/75 between DMA and Green Spring at the low end, with a 25 DMA/50 Additional Services/25 Green Spring split for savings above $4 million. Excess spending was also borne on a sliding scale basis, with Green Spring absorbing all losses at the low end and splitting losses with DMA on a 25 Green Spring/75 DMA basis for any amount over $4 million.[27]



Source Responses to DMA's 1995 RFP
Proposed capitated rates multiplied by anticipated enrollment

DMH

The Partnership came in higher than most bidders on administration of the DMH program, although its rate of earnings was mid-range. It proposed an earnings rate of 8%[28] compared to the 14% suggested by Liberty Healthcare Corporation.[29] The Partnership's proposed direct and indirect costs were about 20% lower at $1 million,[30] with Liberty seeking about $1.2 million dollars.[31] CMG's administrative costs were projected as about $546,000 with an earnings rate of 4.5%.[32] Green Spring projected $586,000 in administrative costs with a 6% earnings rate.[33] MHMA proposed administrative costs of almost $940,000 with a 15% earnings rate.[34]

The Partnership was on the low end of the bids with respect to expenditures for DMH services: $32 million compared to Green Spring's high of almost $44.7 million,[35] Liberty's $37.7 million,[36] MHMA's near $37.2 million[37], and the only lower bid, CMG's near $30 million.[38] Of the $32 million, the Partnership proposed to spend almost $22.4 million on Emergency Service Programs, $9.6 million on hospital services, and only about $75,000 on crisis stabilization.[39]

The Partnership proposed keeping 20% of savings on DMH service costs up to $250,000, bearing 20% of losses up to $350,000, keeping all administrative savings up to 10% of administrative expenditures, pocketing a $50,000 incentive payment if the standard of identifying 50% of enrollees as Medicaid recipients is achieved, and taking 5% of third party collections above $1.5 million.[40]

THE CONTRACT

Overall, the contract primarily addresses provider concerns with MHMA, such as late payment of claims. Nevertheless, there are provisions that could extend some of the civil and human rights currently observed in public facilities to private facilities. Still, the key to determining the future of mental health care for the Massachusetts poor lies in the contract's financial details. Even careful examination of these provisions only gives us limited insight: DMA and the Partnership may renegotiate all financial arrangements for the second and third contract years.[41]

DMA Financial Arrangements

Capitation - the service component

The contract's most striking feature is the vastly reduced capitated rate for disabled recipients of Medicaid.[42] The service component for disabled recipients is $68.33 per recipient per month,[43] as compared to the 1996 rate of $95.87 paid to the former contractor, MHMA.[44] By contrast, the service component of the capitation rate for AFDC recipients is actually slightly higher than that paid MHMA:

$23.93[45] as compared to $23.58.[46] Nevertheless, these capitation rates could result in fewer services for AFDC recipients if one compares actual expenditures of MHMA to the Partnership's estimated expenditures, the latter of which is derived by multiplying the anticipated number of recipients by the Partnership's capitation rates.[47]

Capitation - the administrative component

Profit is only part of the calculation of the administrative component of the capitation rate, which is the sum of:

* Direct costs: the costs of the contractor "directly related" to delivering its (not providers') services;[48]
* Indirect costs: the cost of management, financial or other corporate functions provided in support of the operation of Medicaid managed care program,[49] e.g., parent company costs;
* Earnings (profit).[50]

Direct and indirect costs are so generally defined that it would be difficult, for example, to determine whether and how much of the executives' salaries of the two parent companies are included in indirect costs, or even whether the cost of corporate functions includes an element of profit to the parent companies. However, at least for the first year, limits are placed on these administrative costs: about $13 million for direct costs and $1 million for indirect costs.[51]

Bonuses/Sanctions

The structure of bonuses and sanctions relies more heavily on the carrot than the stick to improve performance. Most bonuses for performance reward $333,333, while most sanctions are topped at $200,000.[52] The total maximum for sanctions in the first year is $1.6 million,[53] while the Partnership may cumulatively earn almost $3 million for meeting the contract's DMA performance standards.[54] Those performance standards are as follows:

* Discharge from inpatient facilities to be followed by outpatient visit within 3 days;
* Readmission to inpatient facilities within 7 days not to exceed 5% during the first contract year;
* Decisions as to inpatient admission to be rendered within an as yet undefined number of hours after receipt of information from an emergency services program;
* Referrals to DMH of persons who do not meet DMH eligibility criteria not to exceed 5%;
* Inpatient prior approval decisions to be provided within 3 hours after receipt of required information;
* Continuing care prior approval decisions for inpatient and crisis stabilization services to be rendered within 24 hours after receipt of required information;
* Outpatient prior approval decisions to be provided within 10 business days after receipt of required information;
* Clean claims to be processed within 30 days;
* Reports required by the contract to be submitted in a timely manner.[55]

Most of these standards concern provider relations, a sore subject for the prior contractor, MHMA. The emphasis on prior approval decisions and claims processing is complemented by the provision concerning outpatient visits after discharge from inpatient facilities. Again, discharge planning was noticeably deficient by MHMA's own survey of its providers.[56]

While the three-day timeline for outpatient visits after discharge should help to improve quality of care, the recidivism performance standard using a seven-day period is less than meaningful. Most studies look at recidivism using a 30-day window at a minimum, while the more comprehensive approach looks at the 90-day recidivism rate.

In addition to the $3 million which it can reap from meeting the aforementioned standards, the Partnership may earn another $1 million if it meets or exceeds performance improvement measures. One measure calls for a 10% increase in the number of recipients who, subsequent to discharge, attend a minimum of one outpatient appointment per month for four months. The other measure calls for a 7.5% increase in the number of inpatient hospital charts with evidence of completed discharge information at the time of discharge (from 80% to 87.5%).[57]

Limited risks/High rewards

The limits placed on profit are both direct and indirect, and do not protect against cuts in service to bolster the amount of the capitation rates that may be pocketed by the Partnership, an issue dealt with separately in the contract. Total compensation, including bonuses, incentives, and risk-sharing payments, may not exceed 95% of what DMA would have had to pay for providing the same services on a fee-for-service basis to an equivalent population.[58] Earnings, or profit,[59] for the first year are set at $1,136,778. In the second and third years, earnings are to be 8% of the sum of direct and indirect costs, unless otherwise agreed by the Partnership and DMA.[60] The limit on profit permitted under the designation of earnings does not include a limit on the profits which the company may keep from limiting expenditures on services or from bonuses.

The limit on profit from "underspending," as it is referred to in the contract, is set at 40% of the first $7.5 million of savings, i.e., $3 million.[61] The Partnership is at risk for "overspending" up to a maximum of $7 million (40% of the first $17.5 million).[62]

DMH Financial Arrangements

Unlike DMA, DMH is paying the Partnership a lump

sum for administration and a lump sum for services. DMH has budgeted a little over $1 million in the first year for administration, which includes direct costs of about $883,500, indirect costs of about $67,700, and profit at a rate of 8% of costs (maximum of approximately $76,100).[63] If the Partnership spends less than the budgeted amount for administration, it may keep an amount equal to 10% of actual expenses.[64]

DMH has budgeted $28 million for year one services.[65] The Partnership may keep 20% of savings on inpatient and diversionary services up to $250,000.[66] It may not keep any savings on emergency services, although it is liable for all losses from excessive expenditures for these services.[67] However, the Partnership may earn up to $200,000 if 70% or more of the persons receiving services from either designated emergency programs (DEPs) or emergency screening services, emergency services, and short term crisis stabilization services programs (ESPs) are Medicaid-eligible.[68]

Another means by which the Commonwealth is attempting to lessen its costs by increasing payments from others is the incentive payment structure for increasing collections from Medicare and private insurance companies. The Partnership can potentially earn $50,000 if third party payments reach $2.5 million. If third party payments reach $4 million, the Partnership will be permitted to keep an additional $105,000. The Partnership may keep 10% of all third party payments above $4 million.[69]

Provisions concerning reimbursement of providers for particular services have caused an uproar in the provider community. Where relevant, providers are required to deduct anticipated payments from third party payors (public and private insurance), the Uncompensated Care Pool, and consumers in their calculation of the amount to be reimbursed by the Partnership.[70] This follows DMH's prior reimbursement policy. Hospitals are concerned about the requirement that providers accept all enrollees who are ordered to be temporarily hospitalized[71] regardless of medical neccessity, as the Partnership will reimburse only for those services that it determines to have been medically necessary.[72] Furthermore, the Partnership will not reimburse providers for inpatient or diversionary services to DMH continuing care consumers with third party coverage for comparable services, *regardless* of whether the individual's coverage is exhausted.[73]

Network Management

The Partnership has indicated, both in trainings of providers and other forums, that it ultimately intends to adopt a hands-off management style with its network providers. Inference is strong that the chosen providers will be the winners of a bidding war between organizations providing comprehensive services – from emergency to inpatient to outpatient care. It is likely that the Partnership will rely heavily on risk sharing and sub-capitation in the second and third years of the contract in order to make its management style financially lucrative.[74] In the meantime, the Partnership will engage in a selective procurement process in which it must balance its desire to prune the network with contractual requirements that services be available and geographically accessible to enrollees.[75]

The Partnership began its tenure with those MHMA providers which returned applications for affiliation. The Partnership planned to distribute requests for proposals early in November 1996, to require the return of letters of intent by mid-November, followed by proposals in early December, and then to score and submit its network recommendations for DMA approval.[76] The procurement process for acute inpatient services is scheduled to be completed by November 30, 1996 and for all other services by December 31, 1996.[77]

Unfortunately, the accessibility requirements, unlike the performance standards listed above, carry no monetary sanctions.[78] The contract states that 90% of enrollees shall have access to non-emergency inpatient services within 60 miles or 45 minutes travel time and to all other services within 20 miles or 30 minutes travel time.[79] Emergency service must be provided immediately, urgent care within 48 hours, and non-urgent care within ten working days.[80]

Recipients are permitted 12 outpatient sessions without prior approval.[81] In addition, the Partnership is to develop a plan whereby enrollees have the option of changing providers within the network.[82]

Quality is to be ensured through a variety of means. DMA is to set up three advisory councils: consumer, family, and professional.[83] It suspended the latter, however, in August 1996, ostensibly to restructure the group, but with the stern warning that meetings of the council should not be gripe sessions. In addition, the Partnership is required to engage the newly popular machinations of "Total Quality Management," survey providers and enrollees at least annually, gather relevant statistics, and develop outcome measurement tools.[84]

Interagency Relations

By the end of March 1997, the Partnership, subject to review and approval by DMA, must enter into interagency agreements with the Departments of Social Services, Youth Services, Mental Retardation (DMR), and Education, the Massachusetts Commission for the Deaf and Hard of Hearing, the Department of Public Health's Bureau of Substance Abuse, and the Executive Office of Elder Affairs, to ensure coordination of mental health and substance abuse services.[85]

In addition, the Partnership will enter into non-financial affiliation agreements with state-operated community mental health centers (SOCMHCs) for the first two years of the contract. With DMA approval and if the centers meet the Partnership's credentialing, quality and performance

standards, the Partnership will contract to pay the centers for inpatient and emergency mental health services in the third year of the contract.[86] This is a surprising deviation from the Commonwealth's general attempt to cut costs for itself. According to a Partnership representative, referrals to SOCHMCs will be based upon current referral patterns without consideration of whether the enrollee is Medicaid-eligible. For those enrollees referred to SOCHMCs who are Medicaid-eligible, the Partnership will be relieved of the obligation to pay for services, although it will continue to collect the capitation amount for that recipient.

According to some clinicians, DMH now has interpreted its eligibility criteria in a more restrictive manner in response to the joint purchasing venture with DMA.[87] The DMH policy on priority clients is incorporated in the contract, and requires that, to be eligible for services, an adult must have a long-term or serious mental illness, the illness must be severe as indicated by level of functioning, and, generally, the functioning impairments must have been or must be expected to be exhibited for one or more years.[88] Unlike the policy, the guidelines limit serious mental illness to specific DSM-IV disorders, and exclude persons deemed eligible by DMR, as well as persons with substance use related or organic brain disorders unless a "qualifying mental disorder" is the primary disorder requiring treatment.[89] Also unlike the policy itself, the interpretive guidelines specifically establish who, among those eligible for DMH services, will have priority for continuing care services and supports. Among those factors considered in whether a person will be provided services is the involvement of another agency.[90]

Clinical Standards

The Partnership repeatedly has stated that it does not have protocols, such as the ones developed by MHMA,[91] and that it does not plan to develop protocols. Nevertheless, the contract sets out medical necessity criteria for each covered service.[92] The criteria outline the standards for admission, exclusion, continuing care, and discharge. Generally, they represent the policies that treatment is appropriate and that no other less intensive (and less expensive) form of treatment will suffice.

Some of the criteria beg attention because they could be used to deny necessary services. For example, an individual who is actively using unauthorized drugs or alcohol is excluded from day treatment programs.[93] In almost all cases, discharge is considered warranted if progress is not being made toward treatment goals or if consent for treatment is withdrawn and court-ordered treatment is considered inappropriate.[94] Family members are particularly concerned about the application of this standard to acute inpatient services[95] and wonder where the family and enrollee are to turn if the enrollee is discharged in poor condition under these circumstances. "Non-compliance" by the enrollee or family members is also a basis for denial of service authorization in some circumstances.[96]

The criteria for community support services, which are intended to help recipients take care of their needs in the community, have also inspired the ire of family members. Community support services are only available to persons who do "not have adequate family support."[97] Thus, families who are responsive to their members' needs will not be able to obtain much-needed relief.

In general, the criteria appear to be broad enough that the application of those criteria – by both providers and the Partnership – will be more determinative of the accessibility of services than the words on the page.

Authorization of Services

Almost all services require prior authorization, the exceptions being crisis services, including limited inpatient services,[98] and 12 outpatient sessions per recipient.[99] If outpatient treatment is to continue beyond the 12 sessions, the provider must request preauthorization no later than the eighth automatically authorized session.[100] Inpatient admissions, except in emergency situations, must be screened by a Partnership-contracted emergency services provider (ESP).[101]

Human Rights

The contract potentially has some significant protection for the human rights of enrollees. In particular, it requires the Partnership to contract only with those providers which have human rights policies equivalent to those established by DMH.[102] However, the potential of this requirement is diminished in three ways. First, there are no financial sanctions associated with contracting with providers which do not have these policies. Second, the requirements allow for facilities to use the generally vague and worthless human rights policies adopted for JCAHO and other similar organizations and agencies to meet the contract's human rights requirements, as long as those policies are consistent with DMH procedures.[103] Third, the Partnership, two months after it assumed stewardship of the program, still did not have a plan for ensuring that providers would meet this criteria for contracting.

Grievance Procedures

Enrollees will now be sent a copy of the authorization for services given to providers. Unfortunately, the plea of advocacy groups to notify enrollees when the service originally requested by the provider and that ultimately authorized differed fell on deaf ears.[104]

If an enrollee disagrees with a denial of service or change of providers, she or he may appeal to either DMA or the Partnership, or both. Providers do not have the right to appeal to the DMA.[105]

The Partnership must keep a log of oral and written complaints. It must provide written acknowledgement of

receipt of a written complaint within 24 hours, and give the enrollee/provider a written decision within 15 business days from receipt of the complaint.[106] There are two separate routes for clinical appeals (complaints regarding service authorization) and administrative complaints (for example, claims processing).

An enrollee/provider who is dissatisfied with the result of her initial administrative complaint may submit a grievance for review by the Partnership's Internal Grievance Committee.[107] A meeting of this group must be scheduled within 10 business days of receipt of the grievance. The entire grievance process is expected to take no more than 45 days from the receipt of all pertinent information.[108]

Complaints concerning service authorization decisions are subject to two levels of appeal and must be filed no later than 60 days after the date of the non-authorization notice. A Level I appeal goes to a peer reviewer who was not involved in the original authorization decision. Determinations must be made as follows:

1 business day	enrollees currently at an inpatient or diversionary level of care
5 business days	enrollee in outpatient care
15 business days	enrollee already discharged from disputed level of care

If dissatisfied with the Level I decision, an enrollee/provider may request orally or in writing a Level II appeal, which involves a review by the Partnership's Medical Director and/or Assistant Medical Director. A Partnership case manager must request the enrollee's medical records within 24 hours of a Level II appeal request. The provider has 10 business days following the request to submit the documents. Upon receipt of the medical records, the Level I timelines for decisions kick in.[109] Again, if the enrollee, though not the provider, is dissatisfied with the Level II decision, she or he has the right to appeal to DMA.

Conclusion

Once again, there are some promising features to the Partnership/DMA contract, including more active use of peer counseling,[110] and at least a bit more protection of human rights in private facilities. The actualization of this promise will require more than mere lip service, as has occurred with MHMA, which, for example, delivered innovative services to an infinitesimal portion of Medicaid recipients.[111] The more likely future scenario involves a rough ride ahead – severe cuts in services to match reduced capitation rates and reduced public input as DMA becomes a closed book and opts for more formal routes of communication.

ENDNOTES

1. Together, FHC Options and Value Behavioral Health cover more than 26 million lives. FHC Options now manages the mental health care for Commonwealth employees, and has had numerous public contracts, including ones in Tennessee, Colorado, Nebraska, Florida, Virginia (CHAMPUS), and North Carolina (CHAMPUS). FHC Options is owned by First Hospital Corporation/FHC Health Systems, both of which are based in Norfolk, Virginia. Value Behavioral Health, the larger of the two partners, manages the mental health coverage of employees of such giants as General Motors, Sears, and United Parcel Services. Based in Falls Church, Virginia, it is a wholly-owned subsidiary of Value Health, Inc. of Avon, Connecticut.

2. DMA gave M-Power a list of RFP sections that it would allow the group to review.

3. A final hour legislative maneuver spearheaded by Mental Health Corporations of Massachusetts (MHCM), a trade organization representing large mental health clinics, almost derailed the scheduled transfer of management from the then-current contractor, Mental Health Management of America (MHMA), to the Partnership. Language was included in DMH's budget that delayed the transfer of DMH monies to DMA by up to 60 days. MHCM was concerned about reimbursement issues concerning emergency services as well as access to inpatient care, among other issues. MHCM received sufficient assurances that its concerns were addressed so that it agreed not to take DMH to court to enforce the budget language.

4. Principal shareholders of CMG Health, which is based in Maryland, are Humana Inc. and United HealthCare, Inc. Technical Proposal of CMG Health, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, p. 1.

5. First Mental Health, Inc., a subsidiary of First Health Services Corporation, is known in Massachusetts as Mental Health Management of America (MHMA), the managed care organization that held the DMA contract from July 1992 through June 1996. First Mental Health was planning to use the services of U.S. Behavioral Health, another national managed care organization, to provide "technical assistance and oversight." Proposal of First Mental Health, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, p. I-4.

6. Green Spring, at the time of the bid, was a wholly owned subsidiary of six Blue Cross and Blue Shield companies. It was planning to ally with Charter Medical Corporation, in which case Magellan Health Services would acquire 51% of Green Spring's stock and the Blue Cross and Blue Shield owners would drop from six to four. Charter owns two providers, Westwood-Pembroke Hospital and Brookside Hospital, that delivered services under the Medicaid program administered by MHMA. Technical Proposal of Green Spring Health Services, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, Attachment A.1.b (Nov. 14, 1995). Because of this potential conflict of interest, Green Spring was disqualified from the bid award.

7. Intracorp is a wholly-owned subsidary of CIGNA.

8. Reimbursement Proposal of the Massachusetts Behavioral Health Partnership, Worksheet 8 (Nov. 10, 1995)[hereinafter referred to as Partnership Reimbursement Proposal].

9. *Id.*, Worksheet 9.

10. For persons with disabilities:
The proposed reduction was 46.64% of "units". This is achieved through a slight reduction in admissions (1.12%) and a 10% reduction in average length of stay. The Partnership projected a 20% decrease in inpatient under 21 and an almost 11% reduction in the average expenditure per recipient on mental health clinic treatment.
Id. at 11.

For AFDC recipients:
The proposed reduction was 46.65% of "units". This is achieved through a slight reduction in admissions (1.83%) and a 4% reduction in average length of stay. The Partnership projected a 34.5% decrease in inpatient under 21 and a 16% reduction in the average expenditure per recipient on mental health clinic treatment.
Id. at 12.

11. *Id.* at 11-13.

12. Reimbursement Proposal of Liberty Healthcare Corporation and Intracorp in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, Section 6.2 C.2, Worksheet 8, p. 20, and Worksheet 9 [hereinafter referred to as Liberty DMA Proposal].

13. *Id.* at 35-41.

14. Reimbursement Proposal of CMG Health, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, p. 2 [hereinafter referred to as CMG Proposal].

15. *Id.* at 1-4.

16. *Id.* at 4.

17. Reimbursement Proposal of First Mental Health, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, Worksheet 9 [hereinafter referred to as MHMA Reimbursement Proposal].

18. *Id.*, Worksheet 8.

19. Reimbursement Proposal of Green Spring Health Services, Inc. in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, Worksheet 8 (Nov. 14, 1995) [hereinafter referred to as Green Spring Proposal].

20. *Id.*, Worksheet 9.

21. *Id.*, Worksheet 3.

22. Partnership Proposal, Worksheet 3, p. 3. Liberty proposed the lowest number of full-time employees at 75. Liberty Proposal, Worksheet 3. MHMA proposed 115 employees and CMG proposed 125 employees, if subcontractor's employees are included. MHMA Proposal, Worksheet 3; CMG Proposal, Worksheet 3, pp. 8, 23, and 31.

23. Partnership Reimbursement Proposal, p. 24.

24. Liberty DMA Proposal, p. 42.

25. CMG Proposal, p. 42.

26. Green Spring Proposal, Worksheet 10.

27. *Id.*, Worksheet 10.

28. Partnership Reimbursement Proposal, Worksheet 8.

29. Reimbursement Proposal of Liberty Healthcare Corporation and Intracorp in Response to 1995 Mental Health/Substance Abuse Program Request for Proposal, Section 6.2 C.3, p. 24 [hereinafter referred to as Liberty DMH Proposal].

30. Partnership Reimbursement Proposal, Worksheet 8.

31. Liberty DMH Proposal, p. 24.

32. CMG Proposal, p. 63.

33. Green Spring Proposal, Worksheet 8.

34. MHMA Proposal, Worksheet 8.

35. Green Spring Proposal, Worksheet 12. Excluding third party revenues, including money from the uncompensated care pool, Green Spring's proposed expenditures totalled about $44.5 million. *Id.*, Worksheet 11A.

36. Liberty DMH Proposal, p. 25.

37. MHMA Proposal, Worksheet 12.

38. CMG Proposal, p. 64.

39. Partnership Reimbursement Proposal, Worksheet 12.

40. *Id.* at 31-34.

41. The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance Standard Contract, entered into with Massachusetts Behavioral Health Partnership, App. A, § 5.1.D., p. 50 and § 5.2.E., p. 59 (executed July 1, 1996) [hereinafter referred to as "Contract"]. The financial arrangements subject to renegotiation include capitation rates, risk sharing, performance and performance improvement standards. *Id.* § 5.1.D.1., p. 50. The renegotiation process could be critical. For example, the contract states that there will be no performance standards if the parties can not agree on them. *Id.* § 5.1.D.4., p. 51.

42. There is a separate capitation rate for SSI-eligible disabled recipients and AFDC recipients. Each capitation rate is divided into service and administrative components.

43. Contract, App. A, §5.1.A.6.b., pp. 37-38.

44. Source: DMA. The rates paid MHMA may be adjusted further as a result of a reconciliation of actual expenditures and the capitation rate permitted.

45. Contract, App. A, §5.1.A.6.a., pp. 37-38.

46. Source: DMA.

47. Multiplying the Partnership's capitation rates by the projected number of recipients and comparing that total with MHMA's annual expenditures, Mental Health Corporations of Massachusetts (MHCM), a trade organization for mental health clinics, estimated that expenditures for AFDC recipients in 1996 would be cut by almost $29 million compared to estimated 1995 expenditures. Spending for disabled Medicaid recipients was estimated to increase by almost $6 million. Mental Health Corporations of Massachusetts, Inc., Analysis of the Division of Medical Assistance/Massachusetts Behavioral Health Partnership Contract (Sept. 1996). Unfortunately, this analysis does not address whether the prior spending levels were inadequate or exaggerated. The exaggeration could have resulted from a settlement of outstanding claims which was precipitated by the failure of MHMA to process claims in a timely manner. Providers often resubmitted existing claims, thereby inserting the possibility of exaggerated expenditures, although the settlement presumably adjusted for this by paying only a percentage of the outstanding claims.

Sherral Crown, Director of the DMA's Mental Health/Substance Abuse Program, believes that the trade organization's analysis overestimates the cuts by $15 to $20 million by failing to consider: (1) for July 1996, DMA is not paying the Partnership based upon the capitation rates, but has a contract for administrative services only; DMA expects to pay between $10 to $15 million for services that month, and (2) DMA has budgeted $5 million above the capitation rates which it will pay the Partnership for diversionary and outpatient services authorized by MHMA that extended beyond July 31, 1996. However, MHCM presumably included about $12 million in its projection of Partnership expenditures, meaning that, at most, MHCM underestimated Partnership expenditures by $7 million.

Nevertheless, because of Crown's critique, MHCM has revised its estimate of decreased spending to $13 million, and continues to question whether this cut can be achieved without hurting quality of care. Crown believes that better management will allow DMA to cut service expenditures and improve quality of care.

48. Contract, App. A, §2, p. 7.

49. *Id.* at 11.

50. *Id.* § 5.1.A.5.a., pp. 36-37.

51. *Id.* § 5.1.A.5.b., p. 37. The total administrative services budget may not exceed $15.3 million dollars. *Id.*

52. *Id.* § 5.1.C.5., pp. 42-50.

53. *Id.* § 5.1.C.5.a.(11), p. 43.

54. *Id.* § 5.1.C.5.b.-j., pp. 44-49.

55. *Id.* § 5.1.C.5.b.-j., pp. 44-49. Compliance with some of the standards is based on comparisons to the previous contractor's performance in 1995. *Id.* at 43-44.

56. MHMA, MHMA Network Experience with Profile Based 24 Hour Programs -Provider Performance Evaluations (July 28, 1994).

57. Contract, App. A, § 5.1.C.6., pp. 49-50.

58. *Id.* § 5.1.A.2., p. 36.

59. Earnings are defined by the contract as "the revenue or profit to the owners/stockholders..., calculated as a percentage of the sum of the Direct Costs plus Indirect Costs of the Administrative Services Budget...." *Id.* §2, p. 9.

60. *Id.* §5.1.A.5.c., p. 37.

61. *Id.* § 5.1.C.3.c., p. 41.

62. *Id.*

63. *Id.* § 5.2.A.2, pp. 51-52.

64. *Id.* § 5.2.D.1., p. 56.

65. *Id.* § 5.2.A.3, p. 52.

66. *Id.* § 5.2.D.2., pp. 56-57. The Partnership is liable for 20% of excessive expenditures for inpatient and diversionary services, up to $350,000. *Id.*

67. *Id.* § 5.D.3., p. 57.

68. *Id.* § 5.2.D.3.c.5, p. 58. If the Medicaid-eligible proportion of individuals receiving services from DEPs or ESPs is greater than or equal to 50%, the Partnership will be awarded a one-time payment of $50,000. If the proportion is greater than or equal to 60% during the first contract year, the Partnership will be paid another $75,000; if greater than or equal to 70%, another $75,000.

69. *Id.* § 5.2.D.3.c.6., pp. 58-59.

70. *Id.* § 5.2.B.1.a., pp. 53-54 and C.1.a., p. 55.

71. *See* Mass. Gen. L. ch. 123, §23.

72. Contract, App. A, § 5.2.A.5., p. 53.

73. *Id.* § 5.2.A.7., p. 53. *See also id.* § 5.2.C.1.d., p. 55.

74. *Id.* §5.3, pp.59-60. DMA must give prior approval to these arrangements, with sub-capitation permitted in year 2 only if DMA directs it. *Id.*

75. Managed care companies prefer contracting with the least number of entities that allow them to meet their contractual obligations to consumers. Fewer entities mean fewer administrative burdens on the managed care company and increase the company's financial leverage with network providers which are dependent on the company for a large portion of their income.

76. Originally, requests for proposal were scheduled to go out in early October, letters of intent to be returned in mid-October, and requests for proposal to be submitted by the end of October. Presentation of Bill O'Brien, Director of Network Management for the Partnership, at the Aug. 29, 1996 meeting of the MH/SAP Professional Advisory Committee.

77. Contract, App. J.

78. *Id.* App. B, § 4.0, pp. 27-28.

79. *Id.* § 4.01.01, p. 27.

80. *Id.* § 4.01.02., p. 27.

81. *Id.* § 5.03.06.a., p. 36.

82. *Id.* § 4.01.07, p. 28. The plan was to be implemented by November 1, 1996.

83. *Id.* App. A, §4.1.B., pp. 29-30.

84. *Id.* App. B, §6.0, pp. 49-52.

85. *Id.* § 2.06.07.a., p. 22.

86. *Id.* §§ 2.01.08 and 2.01.09, pp. 6-7.

87. *See* Interpretive Guidelines, Determining Eligibility for DMH Continuing Care Services Under Policy #89-3, p. 4 (June 18, 1996) [hereinafter referred to as "Interpretive Guidelines"].

88. Contract, App. G (Eligibility Criteria for DMH Priority Clients, Policy #89-3). It should be noted that the Interpretive Guidelines specifically allow for short-term outpatient services to persons with a perceived severe or persistent mental illness and without other resources prior to the formal determination of eligibility for DMH services. Adults may receive up to 5 sessions and children or adolescents may receive up to 8 sessions. Interpretive Guidelines, p. 19.

89. Interpretive Guidelines, pp. 9-10.

90. *Id.* at 6; *see also id.* at 12. If a child is in the custody of DSS or DYS, DMH places primary case management and service delivery responsibility on those custodial agencies, with the exception of certain inpatient services. *Id.* at 6 and 15.

91. *See* Fendell, *Mental Health Managed Care: Service Expenditures Down, MHMA Profits Up*, 39 ADVISOR 31 (Fall 1993).

92. Contract, App. E.

93. *Id.* at 15-16. Although most programs prohibit a person from attending while under the immediate influence of drugs or alcohol, the prevalent practice is to permit a person to remain in the program unless it is determined that a higher level of care is required.

94. *See generally* Contract, App. E.

95. *See* Massachusetts Behavioral Health Partnership, Provider Handbook (as amended by errata sheet of June 28, 1996), Attachment A, p. 4 (clinical criteria for acute inpatient mental health services) [hereinafter referred to as Provider Handbook].

96. *See, e.g., id.* Attachment A, p. 27 (family stabilization discharge criteria – "The individual, family, guardian and/or custodian are non-compliant in treatment or in following the program rules and regulations, despite attempts to address non-compliance issues.")

97. Contract, App. E, p. 21.

98. In an emergency, an enrollee may be admitted to an inpatient or crisis stabilization bed for 24 hours without prior authorization. An emergency is demonstrated by "symptoms so severe that they would likely result in serious bodily harm, death or harm to others if immediate medical attention is not provided." Provider Handbook, p. 17.

99. *Id.* at 20. Outpatient psychological testing always requires prior authorization, *id.* at 22, as does outpatient acupuncture detoxification services, *id.* at 21.

100. *Id.* at 21.

101. *Id.* at 17.

102. Contract, App. B, § 2.02.07.b., e., and f., pp. 10-11.

103. *Id.* § 2.02.07.e., p. 11 and App. K, Acute Inpatient Standards, § II.2.00.

104. *See* Fendell, *Mental Health Managed Care: Service Expenditures Down - MHMA Profits Up*, 39 ADVISOR 14 (Fall 1993).

105. Provider Handbook, pp. 33-34.

106. Contract, Appendix B, § 3.05, p. 25.

107. Provider Handbook, p. 33. The committee consists of management representatives from the Partnership's Clinical, Quality Management, Medical Affairs, Provider Relations, and Community Relations departments, and "appropriate Senior Management representatives." *Id.* By the end of 1996, this committee is to be expanded to include provider(s), representatives from DMA or DMH, and the enrollee and/or the enrollee's family member. *Id.*

108. *Id.* at 33-34.

109. *Id.* at 34-35.

110. Contract, App. B, §5.01.01.h., p. 29. It is unclear whether the Partnership will actually pay for peer counseling services or merely refer enrollees to such services. *See id.* §5.09, p. 47.

111. Fendell, *Managed Care Update*, 44 ADVISOR 9 (Spring 1996).

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